

# **USAID/RWANDA Integrated Strategic Plan 2004-2009**

## **Volume 3: HIV/AIDS STRATEGY**

This Strategic Plan for Rwanda was assembled by USAID/Rwanda. This Strategic Plan is a “pre-decisional” USAID document and does not reflect results of USG budgetary review.

Additional information on the attached can be obtained from Joan LaRosa, USAID/Rwanda.

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## Executive Summary

In 2001, Rwanda was designated as an Intensive Focus Country by USAID under the Agency's Expanded Response to the Global HIV/AIDS pandemic. Consequently, USAID/Rwanda's funding levels for HIV/AIDS rose from \$4.65 million in FY2001 to \$8.5 million in FY2003 (plus \$4.45million under the President's PMTCT Initiative). With this increase in resources, USAID has become the largest bilateral donor for HIV/AIDS in Rwanda. At present, USAID's HIV/AIDS portfolio includes a wide range of activities including prevention (peer education, Prevention of Mother-to-Child Transmission –PMTCT, Voluntary Counseling and Testing- VCT), clinical care (pilot programs in opportunistic infection (OI) prophylaxis and anti-retroviral treatment), and mitigation (support to orphans and vulnerable children, home-based care, mobilization of churches to respond to HIV/AIDS in their communities).

Rwanda has also been named a Presidential Initiative country for both the International Mother and Child HIV Prevention Initiative and the Emergency Plan for AIDS Relief. Consequently, the Mission's HIV/AIDS resources are likely to rise rapidly over the next few years during the new strategy period from 2004 to 2009. Along with an increase in funding, the initiatives bring greater accountability and reporting requirements for USAID-supported programs and activities. The Bush Administration has directed USAID to strive for "speed, scale, and results" that are directly attributable to the increased investments. USAID/Rwanda will continue to target three key areas – prevention, clinical care, and mitigation. Additional resources will focus not only on these targeted interventions, but also on overall systems strengthening at the decentralized level.

The USAID/Rwanda HIV/AIDS Strategic Plan is an integral element of the overall Health Portfolio whose Strategic Objective is **"Increased use of community health services, including HIV/AIDS."** Comprehensive HIV/AIDS interventions are woven throughout the four Intermediate Results: (1) Sustainability, (2) Access, (3) Quality, and (4) Demand.

In a traditional sense, "community health" is generally understood as services which are provided at community-based locations outside the clinic system. However, when referring to "community health services" in the context of the strategy, USAID/Rwanda envisions an optimized health care system which, irrespective of the location where services are provided, responds to community needs and, more importantly, fully integrates the community as an essential partner, along with health professionals and local elected leaders, in service design, financing, and delivery. The SO focuses on "use" because this is the level which is most directly within the Mission's manageable interest. However, the scope and magnitude of the Mission's HIV/AIDS program will, in turn, result in measurable improvements in the health status of the population and will result in higher level impact, such that the Mission will contribute to 30-50% reduction in HIV/AIDS prevalence in Rwanda by 2008.<sup>1</sup>

The Government of Rwanda (GOR) has undertaken several important initiatives to strengthen the national response to HIV/AIDS, including production of a National HIV/AIDS Strategic Framework, negotiations for reduced costs of anti-retrovirals, integration of HIV/AIDS as a development priority in the Poverty Reduction Strategic Plan, and reorganization of national HIV/AIDS institutions. In addition, the GOR is implementing broad decentralization reforms which effect both health service delivery and local governance. Both the GOR and Rwanda's population consider these reforms as the key to achieving their development goals, including the fight against AIDS. The challenge for Rwanda's development partners is to help clarify new roles and responsibilities at all levels of the decentralized system, and to build adequate capacity to enable health technicians, elected officials and communities fulfill their new mandates.

Rwanda's potential to respond to the development challenge of HIV/AIDS has been significantly boosted by new funding opportunities from the World Bank/MAP, the Global Fund, President Bush's AIDS Initiatives, and possibly from the Clinton Foundation. USAID is playing a pivotal role in helping the GOR coordinate these resources at the central level through long-term technical assistance based at: 1) the National AIDS Commission focusing on the Behavior Change Communication strategy development; 2) at the Office of the Minister of State for HIV/AIDS for coordinating the health sector scale-up for AIDS care and treatment; and 3) at the Treatment and Research AIDS Center, in the MOH, for overall program

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<sup>1</sup> UNAIDS Report on Global HIV/AIDS Epidemic (2002) estimates prevalence in Rwandan women aged 15-24 at 13.44% and in men 5.9% at the end of 2001. USAID will contribute to a 50% reduction in prevalence among women in that age group (i.e. to 7-10% prevalence) and a 30% reduction in men in that age group (i.e. to 3-4% prevalence).

management support. In addition, USAID co-chairs the Donor Cluster for HIV/AIDS and is therefore strategically positioned to leverage its resources with other partners, disseminate lessons learned from successful models, and create effective synergies to maximize results.

Based on seven years of experience implementing HIV/AIDS programs in Rwanda, USAID has learned some valuable lessons: (1) HIV/AIDS activities can not be effectively implemented as a vertical program --- significant effort must be invested to reinforce **overall system capacity**; (2) successful HIV/AIDS activities require a strong **decentralized health care system** where services are provided; (3) significant emphasis needs to be placed on **interpersonal communication** through peers, formal leadership structure at all levels for advocacy, and churches; and (4) significant effort and time is required to ensure the sustainable participation of **grassroots civil society organizations** in the fight against AIDS.

In summary, USAID/Rwanda's HIV/AIDS Strategy builds on existing implementation experience and expertise, complements activities of other donors, and reinforces GOR policies and priorities. Because the MOH has expressed particular concern at the potential imbalance that may result from the infusion of significant HIV/AIDS resources, USAID has been requested to maintain an integrated approach with the goal of increasing overall technical and absorptive capacity of the health care system. Therefore, USAID will support the decentralized system by reinforcing capacity at all levels to maximize the impact of HIV/AIDS resources.

The new strategy marks a significant turning point in USAID's health programming in Rwanda by creating a thoroughly integrated approach. To achieve this objective, the Mission envisions two major bilateral procurements: (1) a Decentralization and Health Financing contract (co-financed and co-managed by the Democracy/Governance and Health teams), (2) an Integrated Service Delivery, Training, and Community Action cooperative agreement, which is translated into French as Communité-Santé-Qualité (COSAQ). Additional, specialized technical assistance will be provided through a limited number of Field Support services. Over the life of the strategy, the Health SO activities will reach 50% of Rwanda's Health Districts (~ 20 out of 39).

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## Acronym List

AD	Administrative District
AIDS	Acquired Immuno-Deficiency Syndrome
AMUR	Association Musulmane du Rwanda
ANC	Ante-Natal Clinic (or ante-natal care)
ARV	Anti-Retrovirals
ART	Anti-Retroviral Treatment
ATRACO	Association of Transport Companies
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CAMERWA	Rwandan Central Pharmacy
CCM	Country Coordination Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CDC	Community Development Committee
CDF	Common Development Fund
CHK	Central Hospital of Kigali
CSO	Civil Society Organization
CSW	Commercial Sex Worker
CVA	Conflict Vulnerability Assessment
DfiD	Department for International Development (United Kingdom)
DRC	Democratic Republic of Congo
DG	Democracy and Governance
DHS	Demographic and Health Survey
DHS+	Demographic and Health Survey plus HIV seroprevalence
EC	European Commission
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EPAR	Emergency Plan for AIDS Relief (USG)
EPR	Protestant Churches of Rwanda
FBO	Faith-based Organization
FHI	Family Health International
FP	Family Planning
FSN	Foreign Service National
GDA	Global Development Alliance
GF	Global Fund for AIDS, Tuberculosis and Malaria
GLIA	Great Lakes Initiative against AIDS
GOR	Government of Rwanda
HBC	Home-based Care
HD	Health District
HIS	Health Information System
IDHP	Integrated District Health Plan
ICRC	International Committee of the Red Cross
IAVI	International AIDS Vaccine Initiative
ICT	Information Communication Technology
IR	Intermediate Result
IRC	International Rescue Committee
IEC	Information, Education and Communication
IMPACT	Implementing AIDS Prevention and Control Activities Project
IPC	Inter-Personal Communication
ISP	Integrated Strategic Plan
IPPF	International Planned Parenthood Federation
KAP	Knowledge, Attitude and Practice survey
KfW	German Development Bank
M&E	Monitoring & Evaluation
MAP	Multi-sectoral AIDS Program, World Bank
MFI	Micro-Finance Institution
MINALOC	Ministry of Local Government and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MOH	Ministry of Health

MSF	Medécins Sans Frontiers
<i>Mutuelle</i>	Pre-payment health scheme
NHA	National Health Accounts
OVC	Orphans and Vulnerable Children
NAC	National AIDS Commission
NCA	Norwegian Church Aid
NGO	Non-Governmental Organization
NUR SPH	National University of Rwanda School of Public Health
OI	Opportunistic Infection
PLWA	People Living with AIDS
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
PNC	Post-Natal Care
PRIME II	Primary Providers' Training and Education in Reproductive Health II Project
PROFEMME	National Women's Association
Project SF	Project San Francisco
PRSP	Poverty Reduction Strategy Paper
PSI	Population Services International
RH	Reproductive Health
RPM+	Rational Pharmaceutical Management Project
Save UK	Save the Children Fund United Kingdom
SIDA	Swedish International Development Agency
SO	Strategic Objective
STI	Sexually Transmitted Infection
TAACS	Technical Advisor on AIDS and Child Survival
TB	Tuberculosis
TRAC	Treatment and Research AIDS Center (MOH)
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USDA	United States Department of Agriculture
USDH	United States Direct Hire
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization

## I. INTRODUCTION

In 2001, Rwanda was designated as an Intensive Focus Country by USAID under the Agency's Expanded Response to the Global HIV/AIDS pandemic. Consequently, USAID/Rwanda's funding levels for HIV/AIDS rose from \$4.65 million in FY2001 to an estimated \$8.5 million in FY2003 (plus \$4.45million under the President's PMTCT Initiative). With this increase in resources, USAID has become the largest bilateral donor for HIV/AIDS in Rwanda, and has played a leadership role in developing national standards and expanding service delivery. At present, USAID's HIV/AIDS portfolio includes a wide range of activities including prevention (peer education for youth, Prevention of Mother-to-Child Transmission, Voluntary Counseling and Testing), clinical care (pilot programs in opportunistic infection prophylaxis and in the introduction of anti-retroviral treatment), and mitigation (support to orphans and vulnerable children, home-based care, mobilization of churches to respond to HIV/AIDS in their communities).

In addition to being a USAID Intensive Focus country, Rwanda is also a Presidential Initiative country for both the International Mother and Child HIV Prevention Initiative and the Emergency Plan for AIDS Relief. Consequently, the Mission's HIV/AIDS resources are likely to rise rapidly over the next few years and the course of the new strategy period from 2004 to 2009. Along with an increase in funding, the initiatives will bring greater accountability and reporting requirements for USAID-supported programs and activities. The Bush Administration has directed USAID to strive for "speed, scale, and results" that are directly attributable to the increased investments. USAID/Rwanda will continue to target three key areas – prevention, clinical care, and mitigation. Additional resources will focus not only on these targeted interventions, but also on overall systems strengthening at the decentralized level.

The USAID/Rwanda HIV/AIDS Strategic Plan is an integrated element of the overall Health Portfolio whose Strategic Objective is **"Increased use of community health services, including HIV/AIDS."** Comprehensive HIV/AIDS interventions are woven throughout the four established Intermediate Results: (1) Sustainability, (2) Access, (3) Quality, and (4) Demand.

## II. COUNTRY SITUATION

### A. CURRENT STATUS OF THE EPIDEMIC

Data Sources and Limitations – In 1988, Rwanda was one of the first African nations to establish a national HIV sero-surveillance program. In 1992, data showed a wide range of seroprevalence rates from less than 1% in certain rural area to 35.7% in some urban sites. Since the devastating genocide and war of 1994, however, collection of reliable data concerning HIV seroprevalence in Rwanda has been limited. In 1996, the Government of Rwanda (GOR) re-instituted an HIV sentinel surveillance system and collected data in 1996 and 1998/99. In 1997, the GOR conducted a household survey in neighborhoods surrounding the sites of the 1996 ANC sentinel surveillance. Unfortunately, methodological shortcomings in these studies render the validity of the data somewhat questionable and variation in site selection, sample sizes, age groups, and target populations over time make trends analysis difficult.

In 2002, the GOR asked the U.S. Centers for Disease Control and Prevention (CDC) to assist in designing and conducting an HIV sero-surveillance survey at 25 ante-natal clinics (ANC) nation-wide. The Ministry of Health (MOH)/CDC data represent the most reliable source of HIV seroprevalence statistics currently available for Rwanda. Despite limitations in quality of the earlier sentinel surveillance data, cautious interpretation can draw some general conclusions about the HIV epidemic in Rwanda. Data from PMTCT and VCT service sites are also useful to cross-validate these findings.

Geographic Patterns – HIV prevalence continues to be higher in urban than rural settings. However, because previous surveys have not included the same sentinel sites or a standardized definition of urban and rural, evaluation of this trend is limited. With this caveat, results from the sentinel surveys at ante-natal clinics (ANC) show the following variation in HIV seroprevalence rates by geographic area:

- ANC 1996: Kigali urban 32.6%, rural site 3.6% (MOH)
- ANC 1997: N/A
- ANC 1998-9: urban range 12.6 - 18.2%, rural range 2.3 -13.2% (MOH)
- ANC 2002: urban range 3.6 - 13.7%, rural range 1.1 - 5.1% (MOH/CDC)

A similar pattern is observed from two other data sets with information on the general population, namely the 1997 household HIV seroprevalence survey and data from 18 VCT service sites, but the latter obviously reflects some selection bias. Again, with these caveats, population-based seroprevalence rates show the following variation by geographic area:

- Household HIV seroprevalence survey 1997: urban 11.6%, rural 10.8% (MOH)
- VCT data 2001-2002: urban 7.0-19.7%, rural 3.7-7.6% (FHI/IMPACT)

Gender variation – Characterization of the epidemic according to differences by gender is also difficult because of limited data especially for men. The two sources permitting gender analyses are the 1997 household HIV seroprevalence survey and the 2001/2 VCT data.

- Household HIV seroprevalence survey 1997: male 10.8%, female 11.3% (MOH)
- VCT data 2001-2002: male 8.3%, female 14.0% (FHI/IMPACT)

Age distribution – Analysis of HIV seroprevalence by age is equally difficult given data availability, quality and comparability. The MOH/CDC 2002 surveillance data show the highest HIV seroprevalence among women 30-34 years (11.3% urban, and 4.7% rural). The VCT 2001/2 data indicate progressively higher HIV seroprevalence with age: the highest rates were among men and women aged 35 years and older. Among women aged 35+ yrs, 32.5% tested positive in urban VCT sites, compared to 10.5% in rural VCT sites. Among men of the same age, 23.5% tested positive in urban VCT sites, compared to 14.4% in rural VCT sites.

It is important to note, however, that HIV seroprevalence among the youngest age groups is not insignificant. The 1997 household HIV seroprevalence survey found 5% HIV prevalence among women aged 15-19 years. The MOH/CDC 2002 data for pregnant women aged 15-19 show 6% prevalence in urban sites, and 3.2% in rural sites. Among women less than 24 years, the VCT data show 8.6% HIV prevalence in the urban areas and 3.4% in rural areas.

High-risk population groups – There are very few seroprevalence studies in Rwanda focusing on high-risk groups. The few studies on commercial sex workers and STI patients are of questionable quality. A small survey in 2000 of the prison population in a secondary city showed 5% prevalence among the male prison population. More recently, in response to the GOR decision to reintegrate 20-40,000 prisoners as part of the *gacaca* process, USAID is supporting MOH/TRAC to offer VCT services for all released prisoners and their partners which should provide additional seroprevalence data. As many of the remaining 80-100,000 prisoners are released over the next few years, USAID will continue to support community-level responses that protect both the receiving population as well as the ex-prisoners. In response to the recent return to Rwanda of soldiers and ex-combatants, the GOR has provided VCT services in the demobilization camps supported by the World Bank. VCT data from the camps indicate a comparatively low rate of infection among returning soldiers, estimated between 3-5%.

Two additional activities in 2003-2004 will complement available information on high-risk groups and inform USAID/Rwanda prevention activities during strategy implementation: a program coverage survey (financed by USAID/W via The Futures Group) and the development of a National BCC Strategy. The former will estimate the number of people in traditional high risk groups such as commercial sex workers, children living on the streets, injection drug users and prisoners. The latter will identify additional groups specific to Rwanda that need to be targeted with special messages for behavior change. The process of developing the National BCC Strategy (to include an evaluation of sexual practices, and an in-depth analysis of BCC activities conducted to date) will bring together a wide range of actors in Rwanda's fight against AIDS and thereby enrich the collective understanding of high risk behavior.

National HIV seroprevalence rate – As evident from the above discussion concerning data sources and reliability, a single national estimate of HIV seroprevalence based upon a reliable population-based survey does not exist yet for Rwanda. However, the patchwork of available data suggest that, while the Rwandan epidemic has not reached the magnitude found in Botswana or Zimbabwe, HIV/AIDS remains a significant threat to overall health and development of the population. Existing data sources have been used to calculate aggregate estimates of national HIV seroprevalence as shown below:

- Household HIV seroprevalence survey 1997: 11.1% (MOH)
- UNAIDS 2002: 8.9% (Epidemiological Fact Sheet)

- VCT 2001-2002: 11.1% (FHI/IMPACT)

The 2002 MOH/CDC ANC data are currently being analyzed along with 2002 National Census data to provide a single national estimate.

AIDS cases – Current statistics on the number of AIDS cases come from the Health Information System (HIS) of the Ministry of Health (MOH), and estimates by UNAIDS. According to the Ministry's Annual Report for 2001, only 17,950 AIDS cases had been reported between 1998 and 2001<sup>2</sup>. Based upon the 8.9% UNAIDS national prevalence estimate, the number of people living with HIV/AIDS among the general population is 500,000. The MOH regards its figure as a significant underestimation of the actual number of cases for several reasons, such as the possibility that AIDS patients are registered under other clinical categories and that many patients may die before ever presenting to the health care system for diagnosis. Other possibilities include reticence of health care providers to label a patient as having AIDS or lack of knowledge regarding the standard criteria for making the diagnosis of AIDS. For these various reasons, the HIS data can be assumed to be incomplete and not an accurate reflection of the AIDS burden in Rwanda.

Conclusion – Because of significant data limitations, it is not possible to present a definitive picture of the current state of the epidemic, much less its evolution over the past decade. In general, however, the patterns observed are consistent with a generalized epidemic. The seroprevalence rate appears to be higher in urban areas compared with rural sites and may be higher in women than in men. Although HIV rates may tend to be higher in older age groups, the seroprevalence among younger adults (15 – 24 years old) is not negligible. Because there is no reliable population-based survey from which a national seroprevalence rate can be calculated, the estimated rate of 8.9% as published by UNAIDS is used for planning purposes in this strategy document.

To provide a more accurate national estimate of HIV/AIDS prevalence, and to serve as a baseline for the HIV/AIDS Strategy, USAID and CDC will support the GOR to conduct a national seroprevalence survey as part of the next DHS in July-August 2004. If the prevalence and incidence estimates differ significantly from the current estimates, the new data will serve as the baseline and the targets will be adjusted accordingly.

## **B. FACTORS IMPACTING THE HIV EPIDEMIC**

Historical context – the Genocide - The evolution of the HIV epidemic in Rwanda has been shaped by the 1994 civil war and genocide in which an estimated 800,000 Rwandans perished. This national tragedy created an environment conducive to a more rapid spread of HIV/AIDS through mass migrations, systematic rape and prostitution, and the rapid growth of prison and refugee camp populations. No definitive studies exist to define the relative contributions of each of these factors to the spread of HIV during this turbulent time, but the impact has been profound in many ways. For example, it is estimated that at least a quarter of a million women were raped during the genocide. Many survivors face significant health complications, including HIV/AIDS, children born of rape with HIV/AIDS, sexually transmitted infections (STI) that increase the likelihood of HIV transmission, as well as emotional trauma and severe social isolation. In addition, a large number of widows and orphans from the genocide are among Rwanda's most impoverished and vulnerable populations that are at higher risk of HIV/AIDS.

HIV knowledge and risk behavior - Table 1 provides data on selected indicators regarding HIV risk behavior for population sub-groups. The text below refers to these data and provides complementary information from the cited references.

Knowledge of HIV and its Prevention: Existing data suggest higher HIV/AIDS awareness levels among Rwandan adults compared to the youth. However, among the youth there is a wide variation: the KAP 2002 study showed that youth aged 15-24 years in secondary school have significantly higher levels of knowledge about AIDS and its prevention compared to out-of-school youth of the same age. Yet, in-school youth represent a very small portion of the youth population: the net enrollment rate in secondary school is only 6-10%, with similar rates for boys and girls. Gender variation in overall awareness is minimal but is slightly more pronounced regarding knowledge of condoms for HIV prevention.

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<sup>2</sup> The HIS provides data from District and Reference Hospitals on number of confirmed cases based on HIV test results. These data do not include "presumed HIV cases" from health centers where HIV testing is not available.

**Onset of sexual behavior:** Sexual debut among Rwandan youth is relatively late compared with other sub-Saharan countries. The DHS 2000 reports the median age at first sex at around 21 years for both men and women. Again, comparison of youth in-school and out-of-school shows that almost twice as many in-school youth have sex before age 18, but this difference is only evident among boys. Among those youth who are having sex, the BSS/Youth study showed that 32% of girls and 40% of boys had more than two partners during the 12 months before the survey. In addition, 54% of sexually active girls had sexual relations with persons older than themselves.

Table 1. Risk factors for HIV/AIDS among selected population sub-groups.

Population Sub-groups	Percent Distribution of Population sub-groups by Selected Risk factors							
	Ever heard of AIDS <sup>3</sup>	HIV Prevention Knowledge <sup>4</sup>		Age of first sex activity <sup>5</sup>		condom use <sup>6</sup>		Ever-tested for HIV/AIDS <sup>7</sup>
		Abst.	condom	≤15	≤18	Ever	last sex	
<i>Pop. 15-49 yr</i>								
Male	99.7	85.1	64.9	9.3	29.5	n/a	50.3	7.1
Female	99.6	76.3	36.9	3.0	26.4	n/a	14.7	4.8
<i>Youth 15-19</i>								
Male	74.9	59.5		19.9	23.3	10.3	19.6	1.2
Female	72.1	55.7		8.9	9.7	10.0	11.3	1.0
<i>In-School Youth</i>								
Male	95.2	77.8	66.7	23.8	40.9	38.2	56.0	10.1
Female	94.5	81.1	50.4	3.9	9.0	47.7	60.0	10.0
<i>Out-of-school Youth</i>								
Male	60.8	45.1	33.9	9.2	22.8	31.2	34.6	4.8
Female	64.8	50.4	27.8	2.3	9.5	16.0	25.6	6.3
<i>Commercial Sex Workers</i>								
	92.7	79.4		20.2	70.1	90.0	81.3	40.4
<i>Truckers</i>	99.0	91.9		n/a		74.4	91.2	28.9
<i>Military</i>	n/a							

**Data Sources:**

- *General Population, 15-49 yrs:* DHS 2000, MACRO Internat'l., sample size 10,421 women and 2717 men.
- *Youth, 15-19 yrs:* BSS, 2000, IMPACT/Rwanda, sample size of 4956 from 6 provinces.
- *In-school Youth, 15-24 yrs:* KAP 2002, PSI/Rwanda, sample size of 2145 in 2 provinces.
- *Out-of-school Youth, 15-24 yrs:* KAP, 2002, PSI/Rwanda, sample size of 3109 in 1 province.
- *Commercial Sex Workers:* BSS, 2000, IMPACT/Rwanda, sample size of 699 in 2 cities.
- *Truckers:* BSS, 2000, IMPACT/Rwanda, sample size of 481 from Rwandan truckers on international routes.

**Condom Use:** Among the general population, condom use remains very low. Only 0.4% of women and 1.8% of men reported using a condom during their most recent sexual relation. However, condom use is significantly higher among men (50.3%) and women (14.7%) who have sex with "non-regular" partners. Interestingly, among the youth, a greater proportion report using condoms among "regular" partners, perhaps because there is low reporting of sex with "non-regular" partners. Access to condoms remains a barrier for some population groups: only 27.1% of out-of-school girls and 35% of adult women know where to obtain a condom, compared to 75% of in-school girls. Among both truckers and CSWs, there are high levels of condom use, suggesting that access is not an obstacle.

**VCT:** According to the DHS 2000, 4.8% of women and 7.1% of men reported having been tested for HIV/AIDS. Interestingly, in-school youth reported a slightly higher level of testing, 10% for both boys and

<sup>3</sup> Percent of respondents reporting having ever-heard about HIV/AIDS from any source.

<sup>4</sup> Percent of respondents reporting knowledge of specific modes to prevent HIV/AIDS transmission, based upon spontaneous reporting of condoms and sexual abstinence as such modes of prevention. For youth and CSW, the figure represents % reporting both abstinence and condom use.

<sup>5</sup> Percent of respondents aged ≤15yrs who reported having had sex ever in their life, and percentage of respondents aged ≤18 who reported having had sex ever in their life.

<sup>6</sup> Percent of sexually active respondents who reported ever having used a condom in their life, and among them, the percent reporting having used a condom during the last sexual relations. For adults, this represents the last sexual relation with a non-regular partner, for youth this represents the last sexual relations with regular partners.

<sup>7</sup> Percentage of respondents reporting having ever been tested for HIV/AIDS.

girls. Among the “higher risk” groups, such as truckers and CSWs, the proportion having been tested is significantly higher than the general adult population, and is an encouraging indication that people engaged in high-risk behavior are aware of, and have access to, HIV/AIDS testing services.

Gender relations: Women’s decision-making authority within the Rwandan cultural context is limited to certain issues regarding household management and child-rearing. The DHS 2000 reported that husbands in 47.5% of households had sole decision-making authority regarding their wife’s health. Gender-based violence such as rape, domestic violence, child sexual abuse, and sexual harassment in schools, have all been cited as areas of deep concern. For example, DHS results indicate high acceptance of wife-beating: 48.0% of men and 63.3% of women agreed that burning food, neglecting children, refusing sex, going out without husband, or discussing opinions, are acceptable reasons for domestic violence. Clearly, the status of women in Rwanda vis-à-vis men constitutes a serious risk factor for exposure to HIV/AIDS.

### **C. GOVERNMENT OF RWANDA RESPONSE**

The Government of Rwanda has undertaken several important initiatives to try to strengthen the national response to HIV/AIDS. Several years ago, the GOR negotiated contracts for reduced costs for anti-retroviral (ARV) medications with several major pharmaceutical companies. Since then, generic ARVs are available at approximately \$50 per month, although availability is limited to the capital city where there are 15-20 physicians trained in ARV treatment. Despite the Government’s efforts to secure lower prices and the recent availability of generic brands, ARVs remained too expensive for the average Rwandan.

The GOR has also produced several important policy documents which highlight HIV/AIDS as a national priority. In its **Vision 2020** document, the GOR states that, “Better health care is needed to reverse the decline in health indicators and to confront the major killer diseases, HIV/AIDS and malaria.” HIV/AIDS was also highlighted as a development priority in the **Rwanda Poverty Reduction Strategy Paper** (PRSP) published in 2002. More specifically, malaria and AIDS epidemics ranked among the top ten priorities identified by communities. Proposed interventions include mainstreaming implementation of the multi-sectoral HIV/AIDS program, integration of HIV clients into the pre-payment plans for health care (*mutuelles*), and targeting high risk groups such as youth, truck drivers, CSWs, and others for HIV prevention messages.

In addition to setting national policy objectives, the GOR has taken concrete steps to reorganize its structures to improve its response to HIV/AIDS. In 2001, the former National AIDS Program within the Ministry of Health was replaced by a multi-sectoral National AIDS Commission (NAC) and the Treatment and Research AIDS Center (TRAC) at the MOH. The NAC operates under the auspices of the President’s Office with a board of officers who represent diverse sectors, including religious institutions, the Rwandan military and local government. The NAC’s mission continues to evolve, but its principle responsibilities include: providing policy guidance and strategic leadership to coordinate a multi-sectoral, nation-wide response to HIV/AIDS; ensuring adequate monitoring and evaluation of HIV/AIDS activities; technical assistance and support to decentralized HIV committees to mobilize community responses. An important role of the NAC is to help coordinate and strengthen HIV/AIDS activities in all Ministries, especially Education, Defense, Gender, Youth, and Health. Recent accomplishments of the NAC include the preparation of the **Strategic Framework for HIV/AIDS Control 2002 – 2006** and a **Multi-Sectoral Action Plan**, and the finalization of a **National Monitoring and Evaluation Plan**.

The TRAC is responsible for policy oversight and technical direction for clinical aspects of HIV prevention and AIDS treatment, including VCT, Prevention of Mother-to-Child Transmission (PMTCT) and STIs, HIV laboratory services (CD4 counts, viral load, ELISA HIV tests for quality control), opportunistic infections (OI), and anti-retroviral treatment (ART). Although severely understaffed, the TRAC has been able to produce some concrete results including the publication and dissemination of national VCT guidelines and protocols, the establishment of a PMTCT coordination committee and a national policy, and most recently, protocols for clinical management of OIs at all care levels.

In addition to the reorganization of TRAC, the MOH has also created several new entities in order to respond to the need for better coordination of new HIV resources and activities. The newly established Secretariat for AIDS and other Infectious Diseases, under the leadership of the newly appointed Minister of State for HIV/AIDS and Infectious Diseases, provides oversight for major national HIV/AIDS activities through the TRAC. The same Minister is chair of the Country Coordination Mechanism (CCM) which coordinates Rwanda’s Global Fund activities. The GOR also established a donor coordination Cluster

Group for HIV/AIDS during the Third Annual Rwanda Development Partners Conference in November, 2002, which is co-chaired by USAID and UNDP.

Finally, the GOR continues high-profile advocacy on certain HIV issues. The First Lady of Rwanda convened the first Summit of First Ladies of Sub-Saharan Africa on Children and HIV/AIDS Prevention in 2001 and a follow-on meeting in 2003, and continues to advocate and mobilize the country on sensitive subjects surrounding AIDS such as condoms, social stigma, and sexual violence. The President continues to provide leadership in AIDS prevention and care both nationally and internationally.

#### **D. BACKGROUND/HISTORY OF USAID ASSISTANCE, POST-1994**

Since the 1994 genocide, USAID has provided more than \$200 million in humanitarian assistance for the rebuilding of Rwanda. When the Mission re-opened in 1995, two strategic objectives were established: re-integration at the community level with a special emphasis on women and children, and community health needs, including HIV/AIDS. Key activities included grants to international non-governmental organizations (NGOs) to help communities cope with large numbers of orphans and vulnerable children, financing small grants to women's groups in rural areas, and supporting technical assistance to the GOR to improve community outreach and education for the national STI program.

In 1997, Rwanda was transitioning out of the immediate post-crisis period and into an era of re-building capacity within the health care system. In response, the Mission developed an Integrated Strategic Plan (ISP) whose health sector activities included: training to strengthen accounting and administrative capacities within the health care delivery system; creating a Rwanda Center for Health Communications; and rebuilding two health training institutes which had been damaged during the war. Based on results from the 1996 HIV sentinel surveillance survey, the Mission identified HIV/AIDS as a priority and designed activities to promote the integration of STI/HIV interventions into decentralized health care services.

Since Rwanda's designation in 2001 as an Intensive-Focus Country for USAID, HIV funding levels have increased from \$4.65 million in FY2001 to \$6.5 million in FY2002 to \$8.5 million for FY2003. Consequently, USAID has become the principle donor supporting HIV/AIDS health sector activities and has supported rapid expansion with significant success. As a pioneer in areas such as Voluntary Counseling and Testing (VCT), prophylactic treatment for opportunistic infections, anti-retroviral treatment (ART), and HIV peer education, USAID is strategically positioned to leverage its resources with other partners, disseminate lessons learned from successful models, and create effective synergies to maximize results.

Key areas of USAID assistance over the past two years include:

##### ***Prevention***

Voluntary Counseling and Testing (VCT) - In 2002, national VCT guidelines and training modules were officially disseminated through a USAID-funded partnership with the FHI/IMPACT Project. Access to quality VCT services increased steadily as the number of USAID-supported sites rose from 12 (located in six provinces) in 2001, to 16 (located in seven provinces) in 2002. During FY2002, more than 66,000 people received VCT services at USAID-funded sites.

Prevention of Mother-to-Child Transmission (PMTCT) - Starting in 2002, USAID expanded access to PMTCT services through IMPACT and PRIME II. The six sites funded by USAID in FY02 (out of a total of 33 nationwide) were the first to provide family planning and to focus on quality ANC services as integral parts of a PMTCT program and have now increased to 25 sites under the President's PMTCT Initiative.

Preventive Therapy - In late FY2001, FHI/IMPACT introduced a pilot prophylaxis program for opportunistic infections (OI) and tuberculosis (TB) at two sites and a total of 3,593 patients enrolled for monthly prophylactic treatment. Evidence regarding treatment compliance is encouraging for more advanced clinical treatment for HIV.

Peer Education, Youth - USAID continues to support communication activities for HIV prevention. The number of youth (<25 yrs) involved in HIV peer education activities implemented by FHI/IMPACT doubled from 40,000 (FY2001) to 79,000 (FY2002). This successful peer education curriculum is also being tailored for use by PROFEMME, a national association of women's groups, and for members of the Private Sector Federation, representing employees and employers from businesses nationwide.

Peer Education, Military - USAID supports Population Services International (PSI), through the AIDSMARK project, to implement an interpersonal communication/behavior change communication (IPC/BCC) campaign entitled "A Hero is Always Prepared" to promote preventive behavior including condom use among the Rwandan military. There are now 74 soldiers trained in peer education and they play an active role in co-facilitating IPC/BCC sessions and in targeting activities for soldiers who returned to Rwanda in late 2002 when Rwandan troops withdrew from the Democratic Republic of the Congo.

Peer Education, Churches - World Relief has supported selected church communities to promote discussion and action against AIDS. Church leaders exchange strategies for information sharing; congregations share strategies on social mobilization and home-based care. World Relief is currently working with the NAC to encourage a coherent strategy among all religious institutions following a successful workshop among top religious leaders held in May 2003.

### ***Clinical Care***

Anti-Retroviral Treatment (ART) - USAID/Washington selected Rwanda as one of three African countries to receive core funds to support the initiation of ART for AIDS patients. FHI/IMPACT and the Institute for Tropical Medicine at Antwerp, in collaboration with the TRAC/MOH, have started implementing an innovative approach for HIV/AIDS clinical management, including ART, at two pilot sites in Rwanda. This is the first initiative to effectively decentralize ART to the Health District as the unit of intervention and the first to provide services for a rural population in Rwanda. This activity will also catalyze other MOH partners such as the World Bank, CDC, and the Clinton Foundation who are supporting the roll-out of Rwanda's HIV/AIDS care and treatment program over the next year.

### ***Mitigation***

Community Mobilization - In FY2002, USAID also laid the groundwork for expansion of its community-based care and support activities for people living with HIV/AIDS. With CARE International and FHI/IMPACT, USAID is piloting an activity to understand how communities can mobilize in response to HIV/AIDS through prevention, care, or mitigation in resource-poor environments.

Income-Generating Activities - Additional community level support includes a pilot income-generation activity for members in a Kigali PWLA association through collaboration with a local microfinance organization and World Vision, under a sub-agreement with USAID/IMPACT.

Home-Based Care (HBC) - With USAID support through FHI/IMPACT, the National Association of PLWA is developing a standard home-based care package and is providing HBC services through its member associations.

### ***Central Level Technical Assistance***

Monitoring and Evaluation (M&E) - The GOR has recognized the need for a comprehensive HIV/AIDS M&E system. USAID, through the MEASURE/ Evaluation Project, provides technical assistance to the NAC to help develop a national M&E plan outlining national indicators, data collection schedules, and the framework for donor coordination for funding. The Plan was developed and validated in early 2003 and the NAC is actively preparing its implementation with various partners including USAID.

Health Communication - The NAC also recognizes the need for a coherent and useful Information/Education/Communication and Behavior Change Communication (IEC/BCC) strategy to coordinate the various large and small partners in AIDS communication. USAID supports a long-term technical adviser based at the NAC to assist in developing the strategy and an action plan for its application across all sectors.

Based on the last seven years of experience implementing HIV/AIDS programs in Rwanda, USAID has learned some valuable lessons:

1. HIV/AIDS activities can not be effectively implemented as a vertical program. Because the health care system has such scarce resources and capacity to deliver quality health care services, a significant amount of effort must be invested to reinforce **overall system infrastructure and capacity**.

2. GOR and donor efforts since 1994 have not yet succeeded in rebuilding capacities at the peripheral levels of service delivery. HIV/AIDS activities, especially more advanced services such as management of OIs and administration of ART, can only be successfully accomplished by reinforcing the **decentralized health care system** where services are offered.
3. HIV/AIDS communication and sensitization activities in Rwanda have not yet attained maximum impact primarily because effective communication channels have not been used. Significant emphasis needs to be placed on **interpersonal communication** through peers, formal leadership structure at all levels for advocacy, and churches for “moral guidance” on an issue still highly stigmatized in Rwanda.
4. **Associations of people living with HIV/AIDS** are key partners for implementing effective HIV/AIDS activities but, like many grassroots Rwandan civil society groups, **lack program planning and management skills**. Therefore, significant effort and time is required to ensure their sustainable participation in the fight against AIDS.

#### **E. STRATEGIES AND CONTRIBUTIONS OF OTHER PARTNERS**

Program coordination in HIV/AIDS is a daunting challenge in Rwanda because of the multitude of donors and implementing organizations working in this field. Although a national Strategic Framework for HIV/AIDS has been developed by the GOR, this document has not yet been used effectively as a tool for mobilizing and coordinating donor responses to national HIV priorities. To concisely highlight key donor activities in HIV/AIDS, Table 2 has been compiled from information published in the UNAIDS report **HIV/AIDS Projects in Rwanda** (June 2002) as well as additional program documents for proposed activities to be funded through the World Bank, the Global Fund, and the U.S. Centers for Disease Control and Prevention (CDC).

**Table 2. Summary of HIV/AIDS Activities of Key Donors in Rwanda**

(Note: projects in italics have not yet started implementation)

<b>Activity/Intervention</b>	<b>Donors</b>
<b>PREVENTION</b>	
Health Communication capacity-building	<b>USAID</b> , Action Aid/DFID
Youth Prevention Programs	<b>USAID</b> , MSF, UNICEF, DFID, UNAIDS, Nat'l Society of Sisters of the Red Cross, SIDA, Save UK, UNFPA, Swiss Coop, AMUR, ZOA, IRC
Prevention Programs for other High Risk Groups	<b>USAID</b> (military), DFID (CSWs), IPPF/Japan (CSWs, prisoners), ICRC (prisoners), ATRACO (taxi drivers), UNHCR (refugees), UNDP (military)
VCT	<b>USAID</b> , CDC, MSF, UNHCR (refugees), <i>Global Fund</i>
PMTCT	<b>USAID</b> , UNICEF, EGPAF, Project SF, MSF, WHO, French Coop, EPR, <i>PMTCT-Plus, Global Fund</i>
STIs	<b>USAID</b> , WHO, <i>Global Fund</i>
Sero-surveillance	CDC
Behavioral studies	<b>USAID</b>
Blood safety	WHO, EC
Condom Social marketing	KFW
HIV vaccine	Project San Francisco with IAVI grant
<b>CLINICAL CARE</b>	
OIs	<b>USAID</b> , MSF, <i>Global Fund</i>
ART	<b>USAID</b> , <i>World Bank MAP</i> , <i>PMTCT+</i> , <i>Lux Development</i>
TB	<b>USAID</b> (prophylaxis), <i>Global Fund</i>
Payment for/provision of medical services	Save UK & Christians of Italy/Switzerland/Germany (HIV orphans/families), Caritas (orphans, CSWs), Belgian Coop (CHK), SURF & Survivors Fund/UK (female victims of violence), UNHCR (refugees), Nat'l Society of Sisters of the Red Cross, AMUR (Muslim community), Pangaea (Family Care Package)
<b>MITIGATION &amp; SUPPORT</b>	
Community mobilization and prevention	<b>USAID</b> , NCA, Community Fund UK, DFID, Canadian Coop, PROFEMME, <i>World Bank (MAP)</i>
Nutrition/food support	<b>USAID</b> , WFP
Support to PLHA organizations	<b>USAID</b> , UNDP, UNAIDS, UNFPA, NCA, <i>Global Fund</i>
Support to orphans and vulnerable children	<b>USAID</b> , Caritas, Save UK & Christians of Italy/Switzerland/Germany, AMUR
<b>CROSS-CUTTING ISSUES</b>	
Drug logistics and management	<b>USAID</b> (contraceptives/condoms)
Purchase of drugs	<b>USAID</b> , <i>PMTCT-Plus, Global Fund</i>
Purchase of test kits, etc.	<b>USAID</b> , <i>Global Fund</i>
Monitoring and Evaluation	<b>USAID</b> , CDC, MAP
HIV National Reference Laboratory	Lux-Development, CDC
Regional Response to HIV/AIDS	UNAIDS (GLIA)
Support to NAC	<b>USAID</b> (M&E, IEC/BCC), Action Aid/DFID (provincial/district HIV councils), UNDP (institutional support)
Support to TRAC	UNICEF (staffing), CDC (program management, testing quality assurance, M&E, surveillance, computers, staffing) WHO (staffing)
HIV Policy/Legal Framework Development	UNDP
Other	<i>World Bank MAP</i> (support to line Ministries for implementation of HIV plans)

The Global Fund to Fight AIDS, Tuberculosis and Malaria - The contribution of the Global Fund to HIV/AIDS programs in Rwanda will be significant and has had a marked impact on the design of USAID activities under the new Strategy. With \$14.9 million, Rwanda's Global Fund project's principle goal is to extend "integrated VCT" services to 117 sites in Rwanda, reaching three sites in each of 39 Health Districts over three years. The integrated VCT model includes a spectrum of supportive services for clients who are found to be HIV-positive, including referral to TB clinics for screening, prophylaxis and/or treatment, linkages to community-based home-based care and psychosocial support organizations, and management of opportunistic infections and sexually transmitted diseases. In addition, PMTCT services will be available at each Global Fund site and will be linked to other clinical services such as nutritional support and post-natal follow-up.

World Bank Multi-sectoral AIDS Project (MAP) - The World Bank signed a grant with GOR for approximately \$30 million over five years to support four types of activities. First, MAP funds will be available to help line Ministries implement their multi-sectoral HIV action plans. Second, MAP funds will be channeled through selected NGOs to offer sub-grants to community organizations and other groups so they can respond to local HIV/AIDS challenges. Third, the MAP will provide much-needed funding in direct support of decentralized administrative structures for design and implementation of small local projects for HIV prevention, care, or support. Finally, the MAP includes \$10 million for ART in three provinces, reaching approximately 2,300 individuals. With technical assistance from CDC, the MAP will support the decentralization efforts of the GOR to provide comprehensive HIV/AIDS care in 13 district hospitals in the three provinces.

The Clinton Foundation - A potential new partner for HIV/AIDS interventions in Rwanda is the William J. Clinton Presidential Foundation. Under a Memorandum of Understanding, signed in September 2002, Clinton pledged to assist the GOR with a rapid and comprehensive scale of care and treatment for AIDS patients, including the provision of ARVs. In May 2003, President Kagame's Cabinet approved the **National HIV/AIDS Care and Treatment Plan** which seeks to assure comprehensive care for at least 60% of all Rwandans in need of HIV/AIDS care. USAID is collaborating closely with the Clinton Foundation and the GOR to enhance the national response through a coherent plan seeking to achieve results while establishing sustainable health systems. USAID/Rwanda will enter into a Global Development Alliance (GDA) with the Clinton Foundation as a prelude to the new strategy. Possible areas for partnering include support for procurement and logistics for medical supplies, rapid scale up of training for health care professionals, and systems and institution strengthening. Given the intense needs for overall systems and institutional reinforcement in Rwanda, it is proposed that the major partners identify together with GOR their most appropriate niche based on comparative advantage of the partner and priority need stated by the GOR. For example, USAID's comparative advantage is at the peripheral implementation level whereas the Clinton Foundation would concentrate on institution and systems strengthening at the central level, and include urgent reinforcement of infrastructure and equipment.

As of submission of this document, the Clinton Foundation is actively fundraising among European bilateral donors and pharmaceutical agencies for an estimated \$200 million to finance Rwanda's National AIDS Care and Treatment Plan. If successful, these funds will jumpstart the introduction of ART in the USAID target Health Districts. The Clinton Foundation has not identified specific sites yet, but has confirmed adequate resources to provide ART treatment for approximately 60% of all infected persons in Rwanda who are clinically eligible. These plans suggest that funding and supplies will exist to meet demand, and the weakest link will be the capacity of personnel, facilities, and support systems to deliver services.

Other USG Partners - USAID works in close collaboration with the U.S. Embassy and CDC with regard to HIV/AIDS programs. USAID and CDC have a long-standing collaborative relationship that is being strengthened through the President's Mother and Child HIV Prevention Initiative and soon, the President's Emergency Plan for AIDS Relief. Together, USAID and CDC have developed joint work plans for the PMTCT Initiative and will implement jointly in selected technical domains. USAID and CDC provide technical support for the U.S. Mission HIV/AIDS Committee that guides prevention and treatment activities for all employees of USG agencies working in Rwanda. In addition, the U.S. Defense Attaché is designing a new HIV/AIDS initiative between the U.S. and Rwandan military. The only role envisioned for USAID at this point is to provide background documents and facilitate coordination. The National Institutes of Health of the U.S. Department of Health and Human Services also provides funding for HIV/AIDS research in Rwanda through grants with the University of Alabama/Birmingham. USAID staff keep abreast of research activities such as the study on VCT among couples, so that lessons learned and significant research results can be used to inform and fine-tune prevention messages and programs.

## **F. CONSTRAINTS TO AN EFFECTIVE RESPONSE**

Health System Infrastructure - The legacy of the genocide is still felt throughout the health care system in Rwanda. Although most health care facilities were rebuilt or replaced after the war, many centers still lack necessary infrastructure, equipment, and supplies. For example, a survey of twelve health centers where USAID supports VCT services showed that only three of these facilities had access to functional incinerators for medical waste disposal. However, most of the incinerators were not being used because they were in poor repair, there was no funding to purchase fuel, or the staff was not trained in its operation. According to a recent situational analysis, 45% of health centers have no electricity or generator, and only 73% have an on-site water source. A minority of health facilities surveyed had basic equipment available for infection control, such as sharps boxes for disposing of needles and syringes (43%) and clean gloves (48%). Likewise, many health centers do not maintain adequate levels of essential supplies. During a recent inventory conducted at 124 health centers, 35% had fewer than 100 condoms on hand and 18% of District Pharmacies had no condoms at all in stock, despite the fact that over three million condoms were available at no cost from central stores in Kigali.

Institutional and Human Resource Capacity - A shortage of qualified health care providers and administrators continues to cripple health care delivery in Rwanda. Sixty-five per cent of health facilities in Rwanda are operated through the public system. According to 2000 data from the MOH, however, there were only 144 doctors working in the public sector at that time. According to the same survey, the vast majority of primary health care providers are nurses and "paramedical" providers, representing 60% of the public health workforce. However, the quality of training programs for doctors and nurses in Rwanda is not optimal, adequate clinical training opportunities are not available, and instructors often lack sufficient continuing education in order to keep their own skills and knowledge up-to-date. In a survey of reproductive health (RH) training capacity at eleven nursing schools, for example, only 5% of instructors had received any continuing education in this area and more than 80% of schools did not have any up-to-date RH training materials.

Administrative and management capacity of public health programs also needs reinforcement. Doctors and nurses educated in clinical care often find themselves in management positions as Clinic Directors, District Medical Officers, or MOH officials without any training or orientation to the new skills they need to be effective public health program managers. Moreover, while decentralization of administrative and financial functions is a well-intentioned step toward community empowerment and democracy, the technical capacity of local leaders must be systematically strengthened to keep pace with new roles and responsibilities.

USAID and CDC have included in the Implementation Plan recently submitted for Rwanda's President's PMTCT Initiative for PMTCT, a request for additional funds to conduct a Human Resource Needs Assessment. If approved, this assessment will complement a recent but smaller study conducted by WHO in Rwanda to evaluate needs in terms of clinicians for rapid scale-up of AIDS care activities. A more comprehensive assessment, as proposed by USAID and CDC, which focuses on both clinical and social support personnel will provide a valuable tool to orient both donors and government offices.

Health Care Financing - There is a significant shortage of public financing for the Rwandan health sector. The National Health Accounts study of 1998 showed that 50% of health sector costs in Rwanda were provided through donor support, with only 9% coming from the GOR. A sizeable 33% were paid directly by households, placing a large burden on limited domestic resources in a country where over 60% of people were living below the poverty level. Another important constraint is the shortage of public financing for the health sector: in 1999, the MOH received 4.2% of the national budget, but this level dropped to only 3.6% in 2001. USAID is currently supporting Rwanda's second National Health Accounts study (2003-2004), which will make it the first country to have data from two consecutive studies on the HIV/AIDS sub-sector.

As expected, costs of health care are a significant barrier for the population needing services. Preliminary evidence suggests that pre-payment health schemes (*mutuelles*) can dramatically reduce this barrier. A 1999 study showed that clinic use increased four-fold from 0.24 visits per year per person at baseline to 1.2 visits per year per member of a *mutuelle*. Because *mutuelles* can improve the population's financial access to health care, USAID will support the GOR in its efforts to expand the system nation-wide.

Quality of health care services – Given all these factors, it is not surprising that the quality of health care at many facilities in Rwanda falls below standard. According to a survey of reproductive health services at selected health facilities, for example, only 20% of doctors and nurses could provide prenatal consultations according to national standards. Only 40% of doctors and 7% of nurses were able to correctly provide client counseling in STIs and HIV. In another study, the package of “basic services” (curative pediatric care, STI services, family planning, prenatal care, immunization, and child growth monitoring) was available at only 63% of health centers. Of the 223 health facilities surveyed (hospitals, health centers, health posts), only 21% offered a basic package of HIV services, defined as counseling, referring/providing testing, home care education, and psychosocial support.

#### **G. NEEDS IN PREVENTION, CARE & SUPPORT**

As noted above, the Rwandan fight against AIDS is still in its infancy: prevention efforts are numerous but not coherent or consistent, clinical care is just beginning and needs to be planned strategically, community support and mitigation are equally underdeveloped domains and require intense coordination and management support. In this context, therefore, the USAID/Rwanda HIV/AIDS Strategy is guided by the National AIDS Commission’s **Strategic Framework for HIV/AIDS Control** which addresses needs in each of these areas. In this recently developed document, the NAC “calls upon all these partners [national and international institutions] to play an active role in the implementation of the policies and strategies that have been identified together during the National Consensus Workshop on the Strategic Framework that is going to guide activities for the next five years.” This Strategic Framework serves as the conceptual basis for Rwanda’s **Multi-sectoral National Plan for HIV/AIDS** which includes five major strategic axes:

1. Strengthening preventive measures against HIV transmission
2. Strengthening the monitoring of the epidemic
3. Improving care provision for infected and affected people
4. Strengthening poverty reduction measures and gender mainstreaming in AIDS control activities
5. Strengthening responses, promoting partnerships and multi-sectoral coordination

As the largest bilateral donor in HIV/AIDS in Rwanda, USAID’s current portfolio includes activities in all five strategic areas defined by the NAC and its partners. Under the new strategy, USAID anticipates a significant increase in HIV/AIDS funding which will allow expansion of on-going and other new activities in support of the national framework as indicated in Table 3.

**Table 3. USAID/Rwanda Contributions to National Strategic Framework for HIV/AIDS Control**

NAC Strategic Axis/ Priority Activity Area	Current USAID Activitie s	Planned USAID Activities	Comments for New USAID HIV Strategy
<b>Axis 1 – Preventive measures against HIV transmission</b>			
1.1 Reduced risk behavior thru IEC/BCC	X	XXX	Provide national level support for IEC/BCC
1.2 Testing and early Rx of STIs and TB	X	XX	Strengthen linkages between VCT services and TB programs
1.3 VCT	XXX	X	Global Fund project will expand VCT to all Health Districts
1.4 Prevent accidental exposure to infection in clinics		X	Improve infection prevention and control measures at clinics
1.5 Condom use	X	XXX	Expand messages promoting use and improve distribution system
1.6 Safety of blood transfusion			Assistance provided by other donors
1.7 PMTCT	X	XXX	Ensure “Basic PMTCT” service package at all health centers and enlarge PMTCT package at selected GF sites
1.8 HIV prevention strategies for migrant populations			NAC/Great Lakes Initiative for AIDS (GLIA)
<b>Axis 2 – Strengthen monitoring of epidemic</b>			
2.1 Case notification of STI, TB, AIDS		X	Improve diagnostic capacity of providers to identify AIDS cases
2.2 Sero-monitoring STIs/HIV and bacteriologic monitoring of TB			Assistance provided by other donors
2.3 Epidemiological studies	XX	XXX	DHS-Plus in 2004/5 to include national HIV sero-surveillance
<b>Axis 3 – Improve quality of care for infected/affected people</b>			
3.1 Training care providers in national standards	XX	XXX	Intensify training/capacity-building in selected Health Districts
3.2 Supply network for medications and medical equipment	X	XX	Provide technical assistance in rational pharmaceutical management and logistics
3.3 VCT in Health Centers	XXX	X	(see above)
3.4 Prophylaxis for OIs/treatment with ARVs	X	XXX	Scale up current pilot activities in OI management and ARVs
3.5 Mobile clinics			May support development of health posts in selected districts
3.6 Basic health care services at community level	X	XXX	Scale up home-based care and other community-based “wrap-around” services for PLWA
3.7 Psychosocial, economic, legal support for target groups	X	XX	Promote policy/legal reform to protect rights of PLWA, particularly related to HIV and the workplace
3.8 Involvement of PLWA in AIDS activities	X	XXX	Expand capacity-building for associations of PLWA, encourage integration into other community services
<b>Axis 4 – Strengthening poverty reduction measures and gender mainstreaming in AIDS control activities</b>			
4.1 Income-generating activities	X	XX	Pilot innovative approaches for PLWA, including support to OVC
4.2 PLWA/family access to services(jobs, education, etc)		X	Improve integration of HIV clients into <i>mutuelles</i>
4.3 Girls/women’s access to socioeconomic activities		X	Design new activities to optimize gender equity
4.4 Legal protection to women/girls against rape and exploitation		X	Train local leaders in children’s rights as a public health issue, support related gender and sexual-based violence activities
<b>Axis 5 – Strengthening responses, promoting partnership and multi-sectoral coordination</b>			
5.1 Regional and international partnerships			NAC/GLIA
5.2 Advocacy to mobilize resources for AIDS control			NAC/Support DG Team activities to strengthen advocacy skills of local Community-based Organizations
5.3 Functional capacities of structures involved in AIDS control	X	XX	Provide intensive technical assistance to the NAC to strengthen capacity in health communication, M&E and management
5.4 Research		X	Operational research related to USAID-funded interventions
5.5 Decentralization of AIDS control activities		XXX	Reinforce administrative and management capacities of local entities that plan and implement decentralization
5.6 Sectoral coordination of interventions		X	Support implementation of NAC Strategic Framework

(Note: number of “X’s” represents relative level of effort)

### III. MISSION STRATEGY

#### A. STRATEGIC OBJECTIVE

Under USAID/Rwanda's new Integrated Strategic Plan for 2004 - 2009, the health strategic objective (SO) is: **Increased use of community health services, including HIV/AIDS.** When referring to "community health services" in the context of the strategy, USAID/Rwanda envisions an optimized health care system which, irrespective of the location where services are actually delivered, responds to community needs and, more importantly, fully integrates the community as an essential partner in all elements of service design and delivery within the Health District. Comprehensive HIV/AIDS interventions will be woven throughout four Intermediate Results designed to improve 1) sustainability, 2) access, 3) quality, and 4) demand for services (see Diagram 1). This strategic approach is fully consistent with Government of Rwanda (GOR) priorities as expressed in the national **Poverty Reduction Strategy Paper** (PRSP).

#### B. RATIONALE

Supporting an Integrated Approach to Health Care - USAID/Rwanda's HIV/AIDS Strategy is designed to reinforce GOR policies and priorities, to build on existing implementation experience and expertise, to capitalize on USAID's comparative advantages, and to complement activities of other donors. The Mission elected not to create a separate HIV/AIDS SO because an integrated approach to systems strengthening and capacity-building is essential to addressing the health needs of the Rwanda population, including the significant challenges of HIV/AIDS. The integrated health approach is also critical to a broader multi-sectoral approach which is needed to build technical and financially sustainable programs.

Moreover, MOH policy mandates an integrated package of basic services at all health care facilities, so programming HIV/AIDS activities in isolation from other health priorities is inconsistent with the structure and function of the Rwandan health care system. In fact, the MOH has expressed particular concern at the potential imbalance within the health care system that results from the infusion of significant resources (USAID, Global Fund, MAP, etc.) just for AIDS. Because of USAID/Rwanda's field experience in supporting integrated service delivery, the MOH has requested that USAID maintain this orientation with the goal of increasing overall technical and absorptive capacity of the system. Accordingly, the Mission has designed a strategy which integrates activities in all four technical priority areas: HIV/AIDS, Population, Maternal and Child Health, and Infectious Diseases/Malaria.

Decentralization – In 1997, the MOH began the process of decentralizing the health care system into Health Districts. More recently, the GOR restructured the local levels of government by establishing 106 Administrative Districts, each governed by a newly elected council of officials including a Mayor and several Vice Mayors. At present, a typical Health District encompasses three to five Administrative Districts, although borders are not always consistent. For example, an Administrative District may straddle two different Health Districts. These geographic problems illustrate that, although the GOR is committed to decentralization, the process has not always been thoroughly planned and executed.

**Diagram 1. USAID/Rwanda Results Framework for Health**

**SO6: Increased use of community health services, including HIV/AIDS**

**Overall indicators:**

- Contraceptive Prevalence Rate
- Condom Use
- PMTCT Use (#HIV+ pregnant women receiving HIV prophylaxis)
- Treatment coverage (#HIV+ individuals receiving ART)
- Use of ITN

- HIV/AIDS, FP, MCH, ID/Malaria, and health care financing remain GOR priorities
- Strengthened coordination among GOR, donors, and NGOs
- Adequate USAID funding in all categories
- Key partners are committed to provide health sector development support
- GOR will meet staffing, decentralization, funding, advocacy commitments
- Avoid regional and national conflict
- Stable poverty levels

**SUSTAINABILITY**

**ACCESS**

**QUALITY**

**DEMAND**

**I.R. 6.1**

Reinforced capacity for implementation of the decentralization policy in target local areas.

**Key Indicator:**

- Integrated health plans with multiple funding sources

*I.R. 6.1.1*

Strengthened capacity of central and local administrations to implement decentralization

*I.R. 6.1.2*

Increased citizen participation in local-level policy and decision-making processes for decentralization implementation

**I.R. 6.2**

Increased access to selected essential health commodities and community health services.

**Key Indicator:**

- Number of Health Districts with 1+ sites providing comprehensive AIDS care

*I.R. 6.2.1*

Improved logistics management systems for selected essential health commodities

*I.R. 6.2.2*

Increased opportunities for community financial participation in health care.

*I.R. 6.2.3*

Expanded range of community health and mitigation services available.

**I.R. 6.3**

Improved quality of community health services

**Key indicator:**

- Number of Integrated District Health Plans approved based on performance indicators

*I.R. 6.3.1*

Improved professional training programs for clinical and public health service providers and managers

*I.R. 6.3.2*

Improved health data collection and management capacities

*I.R. 6.3.3*

Improved supervision and training provided by Health District

**I.R. 6.4**

Improved community level responses to health issues(HIV/AIDS/FP/CS Malaria)

**Key indicator:**

- Comprehensive prevention knowledge: HIV, malaria, unwanted pregnancies

*I.R. 6.4.1*

Reinforced capacity of community groups CBO,FBO, Assoc PLWHA, health providers) to promote positive health behaviors

*I.R. 6.4.2*

Expanded capacity of community groups to respond to needs of vulnerable and at risk populations

Both the Rwandan government and population consider decentralization reforms as the key to realizing their development goals, including health. The challenge is to clarify new roles and responsibilities at all levels of the decentralized system (central level, Administrative and Health District level, and community level) and to build adequate capacity to enable officials at all levels to fulfill their obligations. For example, administrative decentralization reforms require local government officials to assume a greater role in financial management and oversight of service delivery (health and other social sectors) within their jurisdiction. However, many local government officials do not have sufficient experience or resources to fulfill these responsibilities. Likewise, the decentralized health system places significant responsibilities on the health district to manage health services at the district hospital and surrounding health centers. The capacity of the Health District to perform its responsibilities has been significantly compromised by reduced financial resources, following decentralization reforms<sup>8</sup>, and general lack of qualified human resources, as a result of genocide and war. As a result, district hospitals and health centers operate with limited support, both financial and technical, from the health system. USAID must optimize the decentralized system by reinforcing capacity at all levels in order to maximize the impact of its HIV/AIDS and other health resources invested in Rwanda.

The Integrated Community Health Model - Taking into account progress and challenges identified in the current strategy, and requests from the MOH that USAID support the decentralized health system, the new strategy will concentrate primarily on strengthening the Health District (HD) level, with support to selected central-level activities and broad-based support for community mobilization in the selected HDs. Large infusions of funds to district levels from the World Bank's Multi-sectoral AIDS Program (MAP), the Global Fund, and the USG Presidential Initiatives, justify USAID/Rwanda's focus on improving local planning and management systems to more effectively plan and utilize these resources to achieve HIV/AIDS objectives within the context of overall health systems strengthening.

The **district level** focus will be on joint programming of the **Integrated Community Health Model** (see Diagram 2) that is characterized by effective participation across the "triad" of partners composed of:

- Health Technicians: District Health team, hospital and health center personnel
- Local Government: elected leaders in Administrative Districts (AD)
- Community/civil society: community health workers, associations (of women, youth, farmers, etc.) faith-based organizations, community-based organizations, NGOs, etc.

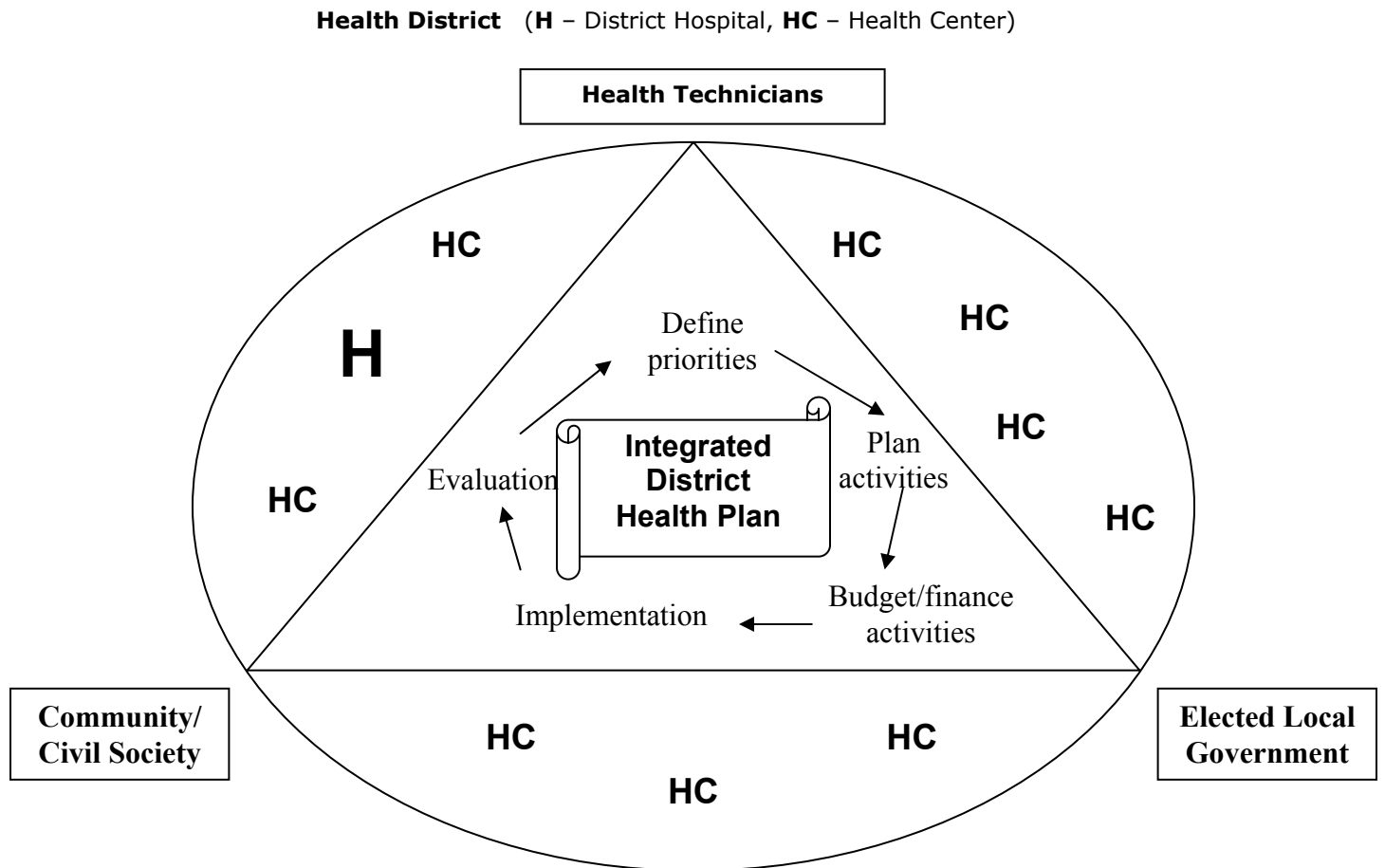
The objective of the Integrated Community Health Model is to promote partnership for the design and implementation of coordinated programming based upon the management cycle: 1) defining priorities, 2) planning activities, 3) budgeting and financing activities, 4) implementing activities, and 5) evaluating results. The product is a single comprehensive Integrated District Health Plan which coordinates activities and maximizes both inputs and results. Strengthened management capacity will result in improved quality of health care delivery and ultimately increased use of services.

The concept of a District Health Plan is not new to Rwanda. What is unique about the Model, however, is that programming of activities and funding will be done jointly with all partners to ensure transparency and efficiency. Moreover, the large anticipated infusion of funds to local levels through projects such as the MAP and the Global Fund will require local planning and management systems which can effectively use these resources to achieve HIV/AIDS objectives. Thus, by promoting the Model, USAID will also enhance the impact of other donor funds at the community level.

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<sup>8</sup> Although decentralization reforms seek to devolve resources and responsibilities for health service delivery to the local level, the process has been slower than anticipated and thus funding flows have been blocked rather than streamlined.

**Diagram 2. The Integrated Community Health Model**



Based upon extensive discussions with the MOH and other donors, USAID's **central-level** support will target the following areas:

- Decentralization Implementation Matrix
- National Health Care Financing Policy (including Health Accounts)
- National Roll Back Malaria Program
- Health Communication (including HIV/AIDS BCC strategy development)
- Drugs and Supply Logistics (including HIV/AIDS and Family Planning)
- HIV/AIDS National Monitoring and Evaluation Plan

USAID's **community-level** support in the targeted Health Districts will include both advocacy and service delivery components:

- HIV/AIDS stigma reduction
- Community-based distribution of selected products (condoms, mosquito nets, contraceptives, etc.)
- Income-generation
- Home-based care, including palliative care
- Orphan support
- Food security and nutrition

Linkages with other Strategic Objectives – Consistent with the multi-sectoral orientation of the National AIDS Commission's Strategic Framework, USAID/Rwanda is designing its HIV/AIDS activities in close collaboration with the Democracy and Governance (DG) team and the Rural Economic Growth team. Perhaps the most innovative element of the new strategy design is the creation of a common Intermediate Result in the DG and Health SO Results Frameworks. IR1 for both teams is "Enhanced implementation of the decentralization policy in target local areas." The specific results are different for each SO with the objective for health being reinforcing the decentralized **health** system through central-level policy development and District-level implementation of the Integrated Community Health Model. Implementation of the jointly-programmed activities to strengthen the decentralized system will be achieved through a single performance-based contract, co-financed and co-managed by the Democracy and Governance (DG) and Health teams. As noted above, an effective roll-out of HIV/AIDS activities will necessarily require significant systems strengthening in both health and management domains, and because of the orientation of decentralization reforms, the management capacity in local government has to be reinforced.

Another area of synergy between DG and Health is through reinforcement of civil society. As the Health SO provides technical assistance and funding support for community-based health activities, the capacity of local organizations such as associations of people living with AIDS (PLWA) or pre-payment health cooperatives (*mutuelles*) for program planning, implementation, and advocacy will increase. The Performance Monitoring Plan for the Health Strategic Objective includes indicators to measure performance of the decentralized health system and to track capacity-building within health related civil society organizations.

The Health SO also has synergies with the Rural Economic Growth Strategic Objective, **Expanded economic opportunities in rural areas**. The two SO teams are currently designing an operations research project to examine the impact of food aid on nutritional status and on "overall well-being" of PLWA, as part of an evaluation of the PL-480 food activities under the Leadership and Investment in Fighting an Epidemic (LIFE) initiative of 2000. This will inform future joint activities linking PLWA, OVC, and other vulnerable populations to agricultural outreach services in order to improve food security and nutritional status.

The Health and Rural Economic Growth SOs are currently co-funding a project to encourage groups receiving micro-credit loans to support community response to HIV/AIDS. The two SO teams will continue to examine how to co-finance microfinance institutions (MFI) to provide group loans to help HIV-positive individuals enroll in *mutuelles*, thus improving financial access to health care for this chronically ill population, and to support small associations of PLWA and other vulnerable groups such as OVC to help them implement income-generating activities.

The scope of opportunities for including HIV/AIDS components in activities under the other two SOs is significant, and will be considered under all procurement instruments oriented towards community response to HIV/AIDS.

### **C. KEY INTERMEDIATE RESULTS**

Development Hypothesis – The Mission’s overall Health Strategy, as well as the HIV/AIDS component of the Strategy, is based on the hypothesis that **if** the community health system (service delivery and promotion of healthy behaviors) can be strengthened by improving the *sustainability* and *quality* of services, and by increasing *access* to and *demand* for those services, **then** the population’s use of community services will also increase. Increased use of community health services and adoption of healthy behaviors will, in turn, result in measurable improvements in the health status of the population and mitigation of the effects of the HIV/AIDS epidemic. At a global level, the Mission anticipates that if the use of community health services<sup>9</sup> is increased, then the health status of the population will improve.

The SO focuses on “use” because this is the level which is most directly within the Mission’s manageable interest. Tracking “use” indicators will help Rwanda contribute data for UNGASS reporting requirements. In addition, the Mission will report on HIV/AIDS impact indicators, including seroprevalence among 15-24 year olds and access to HIV prophylaxis for HIV+ pregnant women, and any other required indicators of the Emergency Plan for AIDS Relief (EPAR).

Target Groups and Geographic Focus – Because reliable surveillance data about the HIV epidemic in Rwanda are scarce, USAID remains flexible in defining target groups for its HIV/AIDS interventions. USAID and CDC are planning to support the GOR to conduct behavioral surveys in 2003 and a DHS-Plus in 2004. As additional information becomes available, USAID will adjust its programming to ensure greatest public health impact. In the interim, it is likely that the following groups will be among those receiving special emphasis in the new strategy:

**Urban populations** – The available data indicate that HIV/AIDS in Rwanda is a generalized epidemic impacting all sectors of the population, but especially in urban areas. Since urban centers tend to have more communication resources (radio, television, cyber cafés, etc.), accessible transportation systems (roads, taxis, mini-buses), more established private sector infrastructure, and more health care facilities, rapid scale-up of behavior change communication programs and expansion of clinical care services for people living with HIV/AIDS should be possible.

USAID has been requested by the GOR/MOH to introduce the Integrated Community Health Model in the two urban districts most affected by HIV/AIDS (located in the capital city Kigali). This will permit intensive focus on key groups which are considered highly vulnerable such as: students in institutions of higher learning (post secondary), transport workers, commercial sex workers, street children, and selected private sector institutions (factories, banks etc.). Based upon assessments to be conducted by key stakeholders in local government and health service delivery, additional high risk groups within these two urban districts will be identified and targeted.

On the national level, additional high risk urban-based groups will be identified during the process of developing the National BCC Strategy (to be completed in 2004). In collaboration with other partners, USAID will also be able to support national interventions that extend beyond those districts where USAID will implement the Integrated District Health Model. Such interventions could be through the national network of faith-based organizations (for example, the Mother’s Union of the Protestant church which has a widespread national presence, or the group of Muslim Women which is most active in urban areas).

**Youth** – The 2000 Youth BSS clearly shows a need for improved knowledge and behavior change among Rwanda’s adolescents. The MOH/CDC’s ante-natal surveillance study confirmed that HIV infection in the younger age groups (15 – 19) was not negligible. As in many developing countries,

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<sup>9</sup> Community health services are defined to include all health services within the Health District, extending from district hospital to health centers to community-based services.

youth make up approximately 50% of the population.<sup>10</sup> A strong and effective program for HIV prevention targeted at youth will be a key element in the new HIV/AIDS strategy, and will be based upon community level mobilization with youth groups following locally-defined strategies and partnerships.

USAID/Rwanda's success over the past years in supporting youth peer education through the network of faith-based organizations will help inform how youth activities will be implemented under the new strategy. Because of the widespread presence and popularity of youth groups within faith-based organizations across the country, these networks constitute one of the most effective channels for targeting youth. A critical lesson learned by various partners supporting youth peer education has been that local leaders (including parents) need to be involved in designing and orienting these activities so that they encourage youth participation (rather than condemning it) and also reinforce the messages (rather than contradicting them). Contrary to expectations, the experience thus far has indicated that both faith-based organizations and local leaders are very supportive of a balanced "Abstinence, Be faithful, and Condom" message if articulated and disseminated in a discreet and culturally appropriate fashion. These lessons will inform both the development of the National BCC Strategy and therefore the tools and approaches to be adopted for USAID/Rwanda's youth interventions.

**Orphans and Vulnerable Children (OVC)** – The escalating impact of HIV/AIDS in the community calls for an increased community response to orphans and other vulnerable children. Rwanda's experience with OVC has most recently been centered on genocide orphans and child soldiers. With USAID-financed assistance, the GOR developed a National OVC Policy which was approved by the Cabinet in December 2002. Support to OVC affected or infected by HIV will be provided through community-NGO partnerships throughout the country with an emphasis on target districts. Using a variety of resources, USAID will support community-based activities to reintegrate demobilized child soldiers and returning refugees, and enable HIV/AIDS child-headed households and OVC to meet their basic needs. There is good potential to increase assistance to OVC as an indirect gateway to helping communities understand the impact of HIV/AIDS and mobilizing communities to respond to the epidemic. A key strategy will be to increase community response to HIV/AIDS impact and to care and support of OVC with particular emphasis on leveraging P.L. 480 Title II and World Food Program (WFP) food aid resources by working with NGOs and FBOs in collaboration with community-based organizations and other civil society groups at the community level.

**Other High Risk Groups** – Because other high risk groups such as truckers and CSWs tend to cluster in urban areas and border towns, a focused HIV prevention intervention targeting these groups is also possible. Promoting access of these groups to VCT and clinical care services can be readily incorporated into the broader context of urban-based services. Service providers caring for individuals who are HIV+ are another high risk group. As part of the overall system strengthening dimension of the strategy and the focus on quality of care, USAID will also target service delivery personnel to ensure application of universal precautions and promote infection prevention to reduce transmission within the health facility workplace.

**Selection of Health Districts** – Because the HIV/AIDS strategy is being implemented within the broader Health SO Framework, selection of Health Districts for USAID support will be based on a number of factors, including but not limited to seroprevalence rates. The Integrated Community Health Model focuses on reinforcing capacities within the decentralized system and requires significant commitment on the part of local leaders in both the Administrative and Health Districts. Given the likely increase in funding with the Presidential Initiatives, the Mission anticipates that it should be able to support implementation of the Model in 50% of the Health Districts (~ 20 out of 39) over the five-year period of the new strategy. Health Districts will be selected through an application process in which numerous factors including health status indicators, linkages with other donor support, political commitment, poverty levels, and community resources will be assessed. It is important to note that some of the greatest health care needs are in rural areas which, although the rates of HIV may be relatively low, will also merit USAID support. The final selection of districts will be based upon a comprehensive review that includes discussions with GOR officials and other donors.

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<sup>10</sup> Preliminary results from 2002 National Census indicate that 48.7% of the Rwandan population is ≤ 17yrs.

Key HIV Approaches - Under the new strategy, there will be three broad types of HIV/AIDS interventions categorized as Prevention, Clinical Care, and Mitigation. Because the strategy is designed to reinforce the decentralized health care system, each intervention will be designed at three different levels, namely, Central, Health District/Administrative District, and Community. These constructs are all integrated into the overall Health Strategy which has four key Intermediate Results (see Diagram 2).

### **Prevention**

The below description of key HIV prevention interventions highlights that linkages between HIV and reproductive health elements are a cornerstone of the integrated approach under this new strategy.

Health Communication - Despite numerous donor interventions in the area of *health communication* for behavior change (BCC), this element of the HIV/AIDS prevention effort in Rwanda remains very weak. Historically, IEC activities have been implemented in the absence of a national framework, have not been designed to reinforce Rwandan institutions to improve IEC/BCC capacity, and have relied too heavily on national level mass media and social marketing, ignoring how Rwandans traditionally communicate and pass information.

Under the new strategy, USAID will provide technical assistance to strengthen national IEC/BCC capacity related to HIV/AIDS.

- At the central level, USAID will support the development of a national communication framework, action strategies, and message cohesion, and will promote coordination through an HIV/AIDS communication and advocacy technical working group<sup>11</sup>.
- At the District level, USAID support will focus on health care staff and local officials to develop capacity in health communication, counseling skills, materials development, and behavior change advocacy.
- At the community level, the HIV/AIDS communication intervention will build upon three existing and effective networks within the Rwandan cultural and political context: faith-based organizations, political and administrative structures, and interpersonal relations.

Rather than being the centerpiece of USAID's communication strategy as in past years, the mass media will be used more specifically to reinforce messages passed through these three more direct communication channels. USAID will improve its youth prevention activities through a more targeted approach based principally on interpersonal communication interventions and expanded peer education. Targeted communication activities for other high-risk groups such as truckers and CSWs may also be implemented under the new strategy depending upon participation of other donors in this key area.

Condoms - Condom use is a critical element in any HIV prevention strategy. At present, the German Development Bank—KfW—provides significant support for social marketing of PSI's *Prudence Plus* brand. Under the new strategy, the Mission will focus on providing adequate supplies of generic condoms through the USAID Global Commodity Fund and on reinforcing the contraceptive/condoms logistics system to ensure their proper distribution and availability at the District and local levels. It is the GOR's policy that these condoms be available at no cost to any individual or organization through the District pharmacies and health centers. Moreover, USAID will promote condom use as well as other HIV prevention behaviors through its health communication activities.

VCT - As noted above, USAID supported the development and dissemination of VCT protocols and guidelines in 2001/2. There are now 22 VCT sites across the country, and although the proportion of overall population tested remains low, the daily demand for services at all these sites exceeds capacity. The Global Fund project will contribute greatly to meeting this demand by supporting 117 sites over the next three years. Central-level support for laboratory quality control and supervision will be provided by CDC through its institutional capacity development at TRAC. USAID support for

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<sup>11</sup> With FHI/IMPACT, USAID is currently funding a long-term advisor, who is based at the NEC, to support the development of the National BCC AIDS Strategy.

VCT will therefore concentrate on reinforcing district-level capacity to provide refresher training, maintain adequate supplies of test kits and reagents, and monitor the quality and use of these services.

Rwanda's national protocol for HIV testing was developed in close collaboration with USAID partners. This protocol is now the standard for use in all VCT and PMTCT service sites, and includes the Determine test which is provided for free by Axios for all PMTCT sites in Rwanda.

PMTCT – USAID and CDC recently submitted three documents – the PMTCT baseline assessment, the initial program plan, and the initial obligation plan for activities under the President's International Mother and Child HIV Prevention Initiative. USAID and CDC will begin implementing activities in July 2003. While CDC will assume central-level support for planning and coordination, quality control, and monitoring and evaluation, USAID will reinforce district-level capacity in these same technical areas for roll out of PMTCT in the context of general Global Fund activities. At present, PMTCT programs operated by TRAC include training and supervision for Nevirapine administration. TRAC plans to expand the definition of PMTCT to include family planning, improved ANC/PNC, and nutrition counseling. In coordination with Global Fund interventions, USAID will help ensure that all health facilities in target districts will be able to provide this basic PMTCT package. An innovative approach called "collaboratives" will be introduced to promote communication among health professionals across districts and sites to facilitate and accelerate sharing lessons learned and achievements in providing quality PMTCT and overall HIV/AIDS care.

STI - Syndromic management of STIs has been Rwanda's policy since the late 1990s. Following recent WHO update of guidelines for syndromic management, Rwanda's guidelines were revised and will be integrated into the Global Fund activities at three sites in every district, as part of the Integrated VCT package. USAID will support similar activities in all USAID-funded sites that are not included under the Global Fund project.

### ***Clinical Care***

Clinical management of *opportunistic infections* and the provision of *anti-retroviral treatment* are daunting challenges for the decentralized health care system in Rwanda. USAID, by virtue of its innovative pilot projects in both of these domains, is ideally positioned to assist the GOR to design and implement a nation-wide scale-up of these advanced clinical services. The strategic issues surrounding scale-up of ART services are particularly complex, and include questions concerning equitable access, objective selection criteria, fee structures for these high-cost services, and shifting the health care paradigm from management of acute disease (such as diarrhea or malaria) to chronic disease.

It is important to note that the CDC and the Clinton Foundation will play critical roles in supporting central level strategic planning and management of HIV/AIDS clinical care, including policy updates<sup>12</sup>, procedures, and guidelines for all aspects of HIV/AIDS management. USAID's role will therefore be to provide complementary support at this level and to ensure that USAID-funded health districts are capable of managing this new and challenging element of decentralized health care delivery.

- At the central level, USAID will collaborate with key partners to formalize a strategic roadmap for expansion of HIV/AIDS clinical services to at all levels of the health care system. As the Chair of the HIV/AIDS Donor Coordination Group, USAID will continue to play an active role in promoting donor coordination and quality assurance by supporting a National ARV Working Group with the TRAC. To respond to the increasing challenge of logistics for drugs and supplies, USAID will support central level systems strengthening through the USAID/W Rationale Pharmaceutical Management Plus (RPM+) Project.
- At the District level, USAID will reinforce management capacities within the Health District team to promote quality services, assure adequate drug and equipment supplies, reinforce referral mechanisms between health centers and the district hospital, and monitor/evaluate

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<sup>12</sup> In February 2003, the MOH published guidelines for clinical care of HIV/AIDS at all three service delivery levels: health centers, district hospitals, and reference hospitals. Home-based care guidelines were also published for extension works from health centers.

health center performance. As noted above in the PMTCT section, USAID will also provide site-specific support to complement Global Fund activities within each district. Depending upon site capacity, USAID will support all sites, whether or not they are included under the Global Fund project, in introducing preventive therapy for OIs, treatment of selected OIs, reinforced TB services, and ultimately ART. Site selection for USAID support will be based upon capacity and other donor coverage, and will include the district hospital if needed. Surrounding these sites, USAID will support community wrap-around services which may include post-test clubs/associations of people living with HIV/AIDS, food support, access to microcredit, home-based care, and life planning assistance (see below for more detailed information).

Since Rwanda is one of the Presidential Initiative countries that will benefit from increased resources from the Emergency Plan for AIDS Relief, USAID/Rwanda plans to increase its efforts in care and treatment by:

- Expanding coverage of ARV treatment at existing sites and new sites within target districts;
- Providing technical assistance to strengthen health district program management and the quality of clinical monitoring at site levels;
- Reinforcing the drug/commodity logistics system at central and district levels.

USAID/Rwanda is already providing ARVs through FHI/IMPACT as a pilot project and expects to substantially expand its investment in care and treatment programs with the increase in funds from the Emergency Plan for AIDS Relief.

Concerning clinical management of Tuberculosis within the context of HIV/AIDS care, existing data indicate that 60% of hospitalized AIDS patients in the central hospital have active TB, whereas the national risk of contracting TB, in the absence of HIV/AIDS, is 2%. Current estimates of the national case detection rate indicate that 50% of cases are identified, which is significantly less than the 70% minimum prescribed by WHO. In light of the urgent need to improve case detection especially in the context of HIV/AIDS, Rwanda's GFATM project for Integrated VCT includes a special component for linking VCT services with TB testing services across the country. USAID/Rwanda will promote this approach as an integral element of clinical care in the Integrated District Health Model, and will also include TB prophylaxis with INH after the protocol that USAID/IMPACT tested over the past 18 months is approved for national dissemination and application.

### ***Mitigation and Support***

Because the full impact of AIDS is felt in the family and in the community, USAID will support a broad-based response that links medical and non-medical mechanisms for support.

Home-based care - In FY2003, USAID is assisting the MOH and an umbrella association of people living with HIV/AIDS (PLWA) to develop standard guidelines and training materials to enable networks of community-based associations and faith-based groups to build and strengthen their outreach to families affected by HIV/AIDS. The Mission will provide training, technical assistance, selected commodities, and ultimately small grants to assist these community groups to integrate such services as home-care kits, nutrition counseling, microenterprise, and legal assistance into their activities. Linking home-based care to health centers to ensure appropriate patient follow-up will be critical to maximizing quality care.

Associations of PLWA - There are currently more than 80 local associations of PLWA across the country. Linking with the objectives of the Democracy and Governance team to strengthen civil society, these associations will be supported to fulfill their role as effective advocates for rights of HIV-positive individuals, reducing stigma associated with HIV/AIDS, and ensuring that PLWA participate in a meaningful way in the planning and implementation of national or local policies and programs designed for their benefit. USAID can support these activities through program design and management training, and with project implementation grants.

Income generation support - Economic concerns about health care, food security and other family needs (such as school fees) consistently rank among the most cited needs for assistance by PLWA. In the new strategy, USAID will expand access to micro-credit through local micro-financing institutions

to target families and other groups impacted by or at increased risk for HIV/AIDS.

Nutrition and food security - Nutrition counseling will be part of clinic-based PMTCT activities, but will also be provided through community outreach by civic organizations, associations of PLWA, or Health Animators. Because expanded nutrition counseling will be part of the integrated Health Strategy, HIV/AIDS clients will also be able to benefit from education services available to the broader population in areas such as pre-natal nutrition, infant feeding and weaning.

Regarding the direct provision food, the USAID Health Program cannot use its HIV funds to purchase food commodities via PL-480, but there are many opportunities for leveraging food resources from the World Food Program and/or USDA Food for Peace (USAID PL-480 Title II Program). Under the new strategy, USAID will collaborate with partners to jointly design and implement innovative approaches for linking food from these alternative sources with clinic and community-based care and support activities in target Health Districts.

In collaboration with USAID/Rwanda's Agriculture and Economic Development SO, a new project has been initiated to promote highly fortified food products in Rwanda. The Health Team is co-funding the production and marketing of highly-fortified products designed and formulated for 3 specific HIV+ target groups: pregnant and lactating mothers, infants born to HIV+ mothers and weaned at 6 months, and individuals with advanced AIDS. The project includes 3 stages. During Stage 1, a Rwandan manufacturer of food products will artificially fortify flour with the prescribed formula of micro-nutrients to ensure immediate availability of fortified foods to be tested for acceptability among the target population groups. During this period, the AgED research partner will promote and distribute local varieties of naturally fortified maize, beans and sweet potatoes to develop local production. During Stage 2, the local manufacturer will procure locally produced highly fortified food products and continue to manufacture the flour and market the product. During Stage 3, local community groups will be trained and provided with credit to develop manufacturing techniques to produce and market fortified food products for the general population. The final objective is that fortified food products specifically tailored for HIV+ target groups are available for all partners, public and private, to procure and distribute through clinics and community care initiatives.

Orphans and Vulnerable Children (OVC) - Essential to USAID's strategy is the prevention of children becoming HIV orphans. This objective is supported by preventing parents from becoming HIV infected (BCC, condom distribution, and VCT) and by improving the health status and life expectancy of those already seropositive by improving clinical management of OIs and by providing ARVs where feasible. To assist families where one or more parent is already infected, USAID will provide training to community groups and faith-based organizations to help reach at-risk families develop succession plans and share labor for farming, for example. By strengthening the social support systems around such vulnerable families, USAID will also be supporting community cohesion and stability. One of the critical challenges facing many OVC is the conflicting responsibilities of assuring labor for family production and attending school. The new strategy will seek innovative links with partners implementing food distribution to target OVC with the objective of increasing school attendance and overall well-being.

Faith-based organizations (FBO) - Because of their strong traditional role in Rwandan society, their large constituencies, and access to resources, FBOs are critical partners in the fight against HIV/AIDS. Many FBOs already support community-based mitigation services for food, economic support, home-based care, and support to HIV orphans. A number of FBOs also support PLWA associations and have education programs in HIV prevention. Under the new strategy, USAID will expand its support for institutional capacity-building among FBOs and will provide mini-grants to enable implementation of grassroots level HIV/AIDS activities.

#### *Cross-cutting Issues*

Under the new HIV/AIDS strategy, USAID will also provide technical assistance to reinforce several key cross-cutting issues.

Drug and commodity management - USAID will build upon its current expertise in strengthening the contraceptives logistics system in Rwanda by expanding technical assistance to include drugs and commodities such as antibiotics for prophylaxis/treatment of OIs, test kits, and ARVs. This is an area

of intense concern for Rwanda given the number of partners intending to support comprehensive AIDS care. USAID is the only partner to date that has committed to supporting both central and district level drug and commodity management for both HIV/AIDS and family planning/reproductive health.

Human Capacity Development - In implementing its new Strategy, USAID will focus on reinforcing technical capacity and training skills within Rwandan institutions. The objective is to promote pre- and in-service performance-based/competency-based training programs that develop and reinforce practical skills of health care providers and managers. To promote sustainability and quality of services, USAID envisions a "cascade" approach to training capacity, beginning with the creation of a foci of technical expertise in key areas (HIV/AIDS, reproductive health/family planning, child survival/malaria, decentralized health care system management, health care financing). These training experts could be located within the MOH, Rwandan health education facilities (nursing schools, Medical School, School of Public Health, etc.), or within the private/non-profit sector (i.e., NGOs) and would be responsible for training of trainers at the Health District level. The Health District teams are responsible for all technical training for health care providers, Health Animators, and, as possible, community groups as well.

Data Collection - Given its comparative advantage in conducting behavioral surveys and population-based health surveys such as the DHS and BSS, USAID will continue to support such activities under the new strategy. The next DHS is scheduled for 2004 and will include a seroprevalence component and an enhanced HIV questionnaire. In addition to behavior studies among high-risk groups and a national survey for seroprevalence, USAID will also continue to support formative research, special surveys, and data collection systems to inform the national HIV monitoring and evaluation plan. It is anticipated that CDC will continue to support the GOR's ANC sero-surveillance system in Rwanda.

Pre-payment health plans (*mutuelles*) - Under the new strategy, USAID will support expansion of pre-payment health plans called *mutuelles* in all target Health Districts as part of the GOR's program to extend coverage nation-wide. USAID is well-positioned to design systems for monitoring the impact of HIV/AIDS on *mutuelle* programs and for assessing the financial consequences on the health care system. The Mission can also help modify *mutuelle* programs so that they are more accessible to the neediest populations, including those infected with HIV.

Information Communication Technology (ICT) - Despite significant infrastructure constraints in Rwanda, ICT can be used to reinforce implementation of the Health Strategy by equipping each District Health team in target areas with a computer and training for developing District Health Plans/Budgets and a local database for performance indicators. Internet connectivity will allow District Health teams to access on-line databases of medical journals and other continuing education materials, and to communicate between themselves regarding program implementation issues. Equipping each District team with a portable laptop computer would also allow team members to provide interactive CD-ROM-based in-service training modules during routine clinical supervision visits. The GOR is currently developing a telemedicine pilot as part of its National Information and Communication Initiative (NICI) which could be integrated into USAID's target districts to further reinforce quality of care. As part of its effort to reinforce the central level of the Ministry of Health, USAID will evaluate the ICT needs and determine an appropriate plan for providing equipment and technical assistance.

Environment - As noted previously, infection control practices and medical waste disposal are sub-optimal at most health centers in Rwanda. Overall promotion of infection prevention will be part of the HIV Strategy, and will include training and technical assistance so that clients and health staff alike are appropriately protected from exposure to HIV. USAID will also assist health centers to develop medical waste management plans and, to the extent possible, and help mobilize funds to implement these plans (i.e., incinerator renovation, purchase of fuel for incinerators, etc.).

Gender equity - An integral part of the new HIV/AIDS strategy will be to promote the empowerment of women through all activities. Funding to district level activities will be made available only when local leaders have demonstrated that women are proportionately represented in all planning activities so that the "triad" truly reflects the composition of the community to be served. Gender awareness training will be included in capacity-building activities for leaders at central, district, and community levels. Community mobilizers will ensure that women are encouraged to actively participate in all

discussions and meetings. Special outreach will be conducted to recruit women's organizations into training sessions and workshops for institutional capacity-building and these groups may be given some preference in scoring eligibility for project mini-grants. In addition, whenever possible, service statistics will be disaggregated by sex to ensure that women have access to services in proportion to their needs.

#### **D. CRITICAL ASSUMPTIONS AND CONCERNS**

To ensure optimum performance and results under the HIV Strategy, several critical assumptions are expected to remain true throughout the duration of USAID activities:

- HIV/AIDS prevention, treatment, and mitigation remain strategic priorities for the GOR.
- Coordination is continued and strengthened among and between the government, donors, and NGOs.
- Other development partners will meet their commitments, most notably:
  - CDC supports central level capacity building for TRAC so it can effectively implement the Global Fund and MAP activities.
  - Other key players (CDC, World Bank, Clinton Foundation) provide major infrastructure support and laboratory equipment at both central and decentralized levels.
- The GOR will meet its commitments to assure:
  - Complete staffing of central-level MOH AIDS program (both at TRAC and NAC)
  - True commitment to the decentralization process, including the provision of adequate funds through the Common Development Fund.
  - An effective mechanism ("Management Unit") for MOH to channel and manage (other) partner funds.
  - Public advocacy for solutions to the HIV/AIDS pandemic.
- USAID continues to receive adequate funding levels (HIV and other) for the duration of the strategy, thus enabling full implementation of planned activities.

In addition to the critical assumptions, there are also several special concerns regarding the political, social, and economic environment that may affect implementation of this HIV/AIDS strategy. Briefly, these are:

- *Mitigating Conflict Potential* – According to a recent Conflict Vulnerability Assessment (CVA), Rwanda does not face imminent risk of internal violent conflict. However, Rwanda is entangled in violent conflicts with neighbors in the region, most notably the Democratic Republic of Congo and Burundi. Other unresolved issues and potential triggers of violence remain, and include:
  - The GOR's emphasis on governance by consensus building and through national mobilization, in the absence of effective structures for the expression of dissent or resolution of grievances. This may lead individuals or groups to resort to armed insurrection.
  - The political system will soon be tested by several specific events, including:
    - Promulgation of new land use/land tenure policies in this poor, densely populated country where land ownership is a key to wealth and security
    - Implementation of *gacaca*, a national community-based judicial system intended to provide justice and reconciliation after the genocide
    - National referendum on a new Constitution
    - National parliamentary and Presidential elections

For the HIV/AIDS sector, assuring equitable distribution of scarce health resources, particularly anti-retroviral treatment, was highlighted in the CVA as an important measure for conflict mitigation. USAID/Rwanda is already addressing this issue in its two pilot ART activities, wherein patients are selected in priority order from three groups: health clinic staff,

clients successfully participating in current opportunistic infection preventive treatment programs, and mothers identified through PMTCT services. Within these groups, clinical selection criteria are used, based on objective findings on physical and laboratory examinations and consistent with international standards for staging HIV disease and for medical contraindications to specific therapies. USAID will continue to provide technical assistance and monitor the ART program and participate in on-going discussions with GOR and partners to identify selection criteria for access to ART.

- *Staffing levels at USAID/Rwanda* – The current staffing level for the Health Team includes one USDH Population Health Nutrition Officer, one Technical Advisor for AIDS and Child Survival, one FSN Program Assistant, and two newly-recruiting FSN technical professionals—a Community Development Specialist and a Maternal and Child Health Specialist. A USPSC Monitoring and Evaluation Specialist who will support all three SOs is currently being recruited, while a new FSN Financial Manager position will be filled in FY2004. With the large influx of additional resources, additional staff will be needed to carry out activities set forth in the Presidential Initiatives.
- *Absorptive capacity of Rwandan development partners* – Given the current level of resources, infrastructure, and qualified staff available in Rwanda to fight the HIV epidemic and considering the large anticipated increases in support from USAID, the World Bank, the Global Fund, and the Clinton Foundation, there is concern about the capacity of GOR structures to absorb and manage these inputs. This could result in significant delays in program implementation and related outcomes. Technical assistance plans from both USAID and CDC are designed to help reinforce central level capacity to effectively manage and coordinate these new resources.

## E. MAJOR PLANNED INTERVENTIONS

In USAID/Rwanda's new Integrated Strategic Plan (2004 – 2009), the Health Strategic Objective as it relates to HIV/AIDS is **"Increased use of community health services, including HIV/AIDS."** In the context of the strategy, USAID/Rwanda defines "community health services" as an optimized health care system which, irrespective of the location where services are actually delivered, responds to community needs and fully integrates the community as an essential partner in all elements of service design and delivery within the Health District.

Because the proposed spectrum of activities is very broad, a significant number of indicators will be tracked by implementing partners for the new strategy.

**In this document, a number of illustrative indicators are highlighted as examples of the types of data that will be collected and monitored. Subsequent to final approval of this document, USAID/Rwanda will work with USAID/W Global Health Office of HIV/AIDS staff to review this list of illustrative indicators and produce the final Performance Monitoring Plan (PMP).**

### Global Illustrative Indicators (all indicators reflect results on national level):

- HIV seroprevalence rate among 15 – 24 year olds [USAID, UNGASS IA1]<sup>13</sup>
- Changes in sexual risk behavior, such as percent of sexually active population with multiple partners, by stable and unstable relationships [USAID]
- Median age at first sex among young men and women [USAID, UNAIDS 9.1]
- HIV seroprevalence rate among the general population [NAC 6.1]
- % of infants born to HIV-infected mothers who are infected [UNGASS IA2]

### Illustrative SO Indicators (all indicators reflect "use" behavior in USAID-funded districts):

- Condom use at last risky sex [USAID, UNAIDS 8.2]
- Number of women attending PMTCT sites for a new pregnancy [USAID]

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<sup>13</sup> UNGASS indicators are divided into the following categories: Global Action (GA), National Action (NA), National Program (NP), Impact Assessment (IA). These acronyms are referred to with the exact indicator number in each category.

- Number of HIV+ women receiving ARV prophylaxis [USAID]
- Number of clients receiving VCT services [USAID]
- Number of HIV+ persons receiving ARV treatment (USAID, NAC 3.5)
- Number of HIV+ persons receiving OI preventive therapy
- Number of clients provided STI services at clinics [USAID]
- Number of individuals reached by community and home-based care programs [USAID]
- Number of orphans and other vulnerable children receiving care/support [USAID]

The SO has four Intermediate Results. For each IR, a brief discussion of the related sub-IRs, illustrative activities, and sample indicators is provided.

#### **IR 6.1. Reinforced capacity for implementation of the decentralization policy in target districts**

In collaboration with the Democracy and Governance SO5, the Health Team SO6 will support MINALOC and MOH to transition more effectively to a *sustainable* decentralized system. The Mission seeks to strengthen the policy environment and implementation of decentralized services at three tiers: 1) enhancing central planning and management systems, 2) improving decentralized (Administrative and Health Districts) planning and management to work toward the Integrated Community Health Model for joint planning and financing, and 3) increasing community participation by strengthening civil society organizations in the entire program management cycle, from initial planning and budgeting through to monitoring and evaluation.

##### IR6.1 Illustrative Indicators:

- # of completed elements in Policy Matrix
- # of Integrated District Health Plans (IDHPs) financed by multiple (3 or more) funding partners (including GOR, CDF, other donors, NGOs, etc.)
- # of IDHPs developed in collaboration with multiple (3 or more) community-based organizations, including at least 1 organization representing PLWAs

#### **IR 6.1.1 – Strengthened capacity of central and local administrations to implement decentralization**

USAID will provide technical assistance and funding support to the central level for advancing and monitoring the practical implementation of decentralization policy. At the Health District level, USAID will support implementation of the Integrated Community Health Model through training in all aspects of the program cycle (planning, budgeting, management and evaluation) and through direct grants.

Illustrative Activities	
Central	<p>Strengthen MOH capacity to develop a National Health Sector Plan for effective coordination of activities and resources (including a Health Financing Policy)</p> <p>Support MOH and MINALOC in identifying and applying policy actions to implement decentralization reforms for the health sector</p> <p>Provide training to MOH staff regarding public health and clinical program planning and management</p> <p>Promote inclusion of PLWHA groups in planning and implementation of central level policies related to HIV/AIDS issues</p>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Provide training and regular on-site support for job competency to ensure effective joint AD/HD planning, budgeting, and managing of health activities</li> <li>• Provide financial support to implement elements of the Integrated District Health Plans, combined with financial and program management training and supervision</li> </ul>

**IR6.1.1 Illustrative Indicators:**

- National Index of Policy Regarding Human Rights [NAC 4.8, UNGASS NA1C]
- Number of donors who provide support to MOH's development of a National Health Sector Plan and Health Financing Policy
- Number of AD/HD leaders trained in participatory planning
- Number of Health Districts preparing and implementing Integrated District Health Plans per year
- Number of HD and health centers with zero fiscal deficit at the end of each financial year
- Number of different sources of financial support contributing to district-level Integrated District Health Plans per year
- Number of AD/HD implementing improved financial/accounting systems (expense records, double entry bookkeeping, for example)
- Number of AD/HD with monitoring and evaluation systems for program and financial management and regularly update and use the data

**IR 6.1.2 – Increased citizen participation in local-level policy and decision-making processes for decentralization implementation**

Another area of synergy between DG and Health SOs is through participatory planning and implementing of Integrated District Health Plans. Emphasis will be placed on strengthening the capacity of community groups to engage in planning processes with the AD/HD partners of the triad, and also to effectively plan and manage their own community-based activities as part of the Integrated District Health Plans.

Illustrative Activities	
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"><li>• Provide training to strengthen linkages between AD/HD leaders and the community through effective participatory planning.</li><li>• Build capacity for local PLWHA organizations, including planning with AD/HD team</li><li>• Sensitize AD/HD leaders regarding PLWA rights and national policies</li><li>• Support AD to train civil society organizations (CSO) in managing development and HIV/AIDS activities</li></ul>
Community	<ul style="list-style-type: none"><li>• Provide training and support for community groups, civil society organizations and vulnerable groups in advocacy, program planning and management.</li><li>• Provide training and support for PLWA associations in advocacy, legal rights, income generation, etc.</li><li>• Sensitize community leaders regarding PLWA rights and national policies</li></ul>

**IR6.1.2 Illustrative indicators:**

- Number of AD/HD leaders trained in participatory planning
- Number of health centers/health committees who have at least quarterly meetings with associations providing support to PLWHA [NAC 3.1]
- Number of organizations which offer programs to protect the psychological and legal rights of PLWA [NAC 3.3]
- Number of District AIDS Committees who have active participation of PLWA [NAC 3.4]
- Percent of population reporting favorable attitude towards community support for PLWA rights [UNAIDS 3.1]
- Number of target CSOs that assess community/client needs in a participatory manner (involving clients) in: a) planning activities (services and advocacy) and b) monitoring
- Number of target CSOs with improved financial accounting practices (expense records, double-entry bookkeeping, etc.)
- Number of target CSOs with strategic plans being implemented
- Number of target CSOs that: a) have monitoring and evaluation systems, b) collect/use resulting data

**IR 6.2. Increased access to selected essential health commodities and community health services**

A critical impediment to use of services is limited access to services. USAID's support will focus on key factors determining access such as the availability of essential commodities (i.e. bed nets, condoms), the client's ability to pay for health care services, and the scope of services that are offered within the health care system.

**IR6.2 Illustrative Indicators:**

- # of Health Districts with at least one site providing comprehensive AIDS care (including VCT/PMTCT, OI prophylaxis and treatment, ART, and community wrap-around services)
- # of Health Districts assuring access to community-based distribution of selected essential commodities

**IR6.2.1 – Improved logistics management systems for selected essential health commodities**

A strengthened logistics system can help ensure that essential health commodities such as contraceptives, medications, bednets, condoms, HIV test kits, etc. are available at service delivery points.

Illustrative Activities	
Central	<ul style="list-style-type: none"> <li>• Provide technical assistance and training to MOH and CAMERWA to enhance the logistics management system for essential HIV/AIDS/STI commodities (i.e. test kits, condoms) and medications (i.e. antibiotics, ARVs)</li> <li>• Provide technical assistance and training to MOH and CAMERWA regarding the rational use of HIV/AIDS pharmaceuticals, including procurement of quality medications, drug security, and scientifically valid treatment protocols</li> <li>• Assist MOH to create an ARV Technical Advisory Board to ensure proper management of HIV/AIDS/STI commodities and medications</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Provide technical assistance and training to Health District pharmacists, supervisors, and health center staff regarding logistics management for HIV/AIDS/STI commodities and medications</li> </ul>

**IR6.2.1 Illustrative Indicators:**

- # Health Centers in USAID-targeted districts with no stock-outs during 12 months of essential HIV, RH, malaria commodities
- Number of health care facilities which have medications for OIs and palliative care in stock [NAC 3.10]
- Annual cost savings at national and district level as a result of rational pharmaceutical management
- Number of Health Districts providing monthly essential commodity and medication reports to MOH and CAMERWA

**IR 6.2.2 Increased opportunities for community financial participation in health care**

In order to reduce financial obstacles to accessing health care, without compromising the sustainability of services, a comprehensive analysis of real costs is required. USAID will support such analyses and based upon them expand access to *mutuelles*, as well as to innovative approaches such as health credits, public works programs, and group loans from local banks or microfinance institutions (MFI).

Illustrative Activities	
Central	Conduct a National Health Accounts (NHA) analysis, including an assessment of the impact of HIV/AIDS on health system expenditures, as the basis for developing a National Health Care Policy <ul style="list-style-type: none"> <li>• Reinforce GOR capacity to support national expansion of the <i>mutuelle</i> program</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Conduct a District Health Account analysis to determine costs for basic and integrated health care service packages including VCT, PMTCT, and ARVs</li> <li>• Test innovative approaches to community health financing (i.e., health credits, public works, loans from local banks, etc.)</li> <li>• expand establishment of <i>mutuelles</i></li> </ul>
Community	<ul style="list-style-type: none"> <li>• Sensitize the community regarding benefits of <i>mutuelle</i> enrollment</li> <li>• Provide technical assistance to increase community participation in management of <i>mutuelles</i></li> </ul>
<b>IR6.2.2 Illustrative Indicators:</b>	
<ul style="list-style-type: none"> <li>- Number of HD with District Health Accounts</li> <li>- Number of IDHPs with line item to cover HIV/AIDS clinical care costs for indigent patients</li> <li>- Percentage of population in targeted HDs enrolled in <i>mutuelles</i></li> <li>- Percentage of <i>mutuelle</i> members who participate in General Assembly meetings</li> </ul>	

**IR 6.2.3 – Expanded range of community health services available**

At present, the minimum package of services according to national protocols is not available in all service delivery sites. USAID activities will help ensure access to the scope of basic services by expanding existing services (i.e., complete contraceptive method mix available at health centers) and by adding new services (i.e., ARVs) at appropriate service delivery sites.

Illustrative Activities	
Central	<ul style="list-style-type: none"> <li>• Provide technical assistance to central level coordinating network and district teams to help other partners expand ARV programs</li> </ul>

Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Provide access to basic PMTCT (including improved ANC/PNC, FP, nutrition counseling) at all health centers in target HDs</li> <li>• Provide on-site training for Health Animators to provide a broader range of community-based commodity distribution (i.e. family planning, bednets, water treatment, etc.) and health education</li> <li>• Support limited, strategic expansion of ARV/OI treatment to at least one health facility per target HD, based on site capacity, HIV prevalence, and Global Fund/Clinton Foundation activities</li> <li>• Strengthen referral networks to improve HIV client access to clinic and community-based wrap-around services</li> <li>• Reinforce Health Center outreach to the community to enhance coordination of HIV/AIDS activities</li> <li>• Train AD/HD staff to coordinate community response to orphans and vulnerable children with local associations of PLWAs and other community groups</li> <li>• Train HD leaders to play an active role in supporting the re-integration of vulnerable children into the community</li> </ul>
Community	<ul style="list-style-type: none"> <li>• Expand microfinance/micro enterprise projects with associations of PLWA</li> <li>• Provide technical assistance and training to strengthen community capacity to provide "wrap-around" services for families impacted by HIV/AIDS <ul style="list-style-type: none"> <li>o Psychosocial and spiritual counseling and support</li> <li>o Linkages to family and community support (including Nutrition, counseling, care and support)</li> <li>o Home-based care programs, including linkages with food assistance programs</li> </ul> </li> <li>• Mobilize community organizations to identify and assist orphans, vulnerable children, and other at-risk groups in order to prevent disintegration of families and minimize risk of HIV/AIDS</li> </ul>
<b>IR6.2.3 Illustrative Indicators:</b> <ul style="list-style-type: none"> <li>- Number of health facilities in USAID target districts providing comprehensive AIDS care (VCT/PMTCT, OI prophylaxis and treatment, ART and community wrap-around services)</li> <li>- Number of Health Animators providing CBD and health education services</li> <li>- Number of pregnant women counseled and tested for HIV [NAC 1.16, UNAIDS 6.1]</li> <li>- Number of pregnant women testing positive at PMTCT sites [NAC 1.19]</li> <li>- Number of HIV+ pregnant women receiving a full course of nevirapine [NAC 1.18, UNGASS NP8, USAID]</li> <li>- Number of HIV+ pregnant women accepting FP</li> <li>- Number of HIV+ mothers and babies returning for at least 1 PNC visit within 6 months after delivery</li> <li>- Number of HD with at least one quality VCT center [NAC 1.12]</li> <li>- Number of (USAID-assisted) ARV treatment programs [NAC 3.9, USAID]</li> <li>- Number of health facilities with trained staff in HD in diagnosis and treatment of OIs [NAC 3.7]</li> <li>- Number of households receiving help in caring for chronically ill adults [UNAIDS 13.4]</li> </ul>	

### **IR6.3. Improved quality of community health services**

Clients will pay for services which they regard as being of good *quality*. Low health care utilization rates in Rwanda are attributable to many factors, including widespread, often accurate, perceptions that the quality of services is poor. USAID will seek to strengthen the quality of decentralized health care services in several ways, including the reinforcement of selected pre-service training programs so that health care staff are adequately prepared with the technical and managerial skills to deliver the required package of quality services in the field.

In addition, USAID will support improved health data collection, analysis, and utilization at all levels of the health care system. This will help clinical and public health care providers and managers make informed, data-based decisions. In addition, the data will link into the National HIV/AIDS Monitoring

and Evaluation plan. USAID will support periodic Behavior Surveillance Surveys in high risk groups every two to three years and is committed to conducting a DHS-Plus in 2004. It is anticipated that CDC will continue to support the ante-natal sero-surveillance program, and will also support MOH/TRAC in informatics and monitoring and evaluation through technical assistance, tools development, and systems strengthening.

In the decentralized health care system, the Health District team has primary responsibility for providing all in-service training and supervision for health care providers in their districts. At present, District teams are understaffed, under-trained, and under-funded to perform this important responsibility adequately. USAID will focus a significant amount of technical assistance and resources at the Health District level to enhance these capabilities.

#### IR6.3 Illustrative Indicator:

- # IDHPs in USAID target districts approved based on performance indicators from service delivery sites within the district.

#### **IR6.3.1 – Improved professional training programs for clinical and public health service providers and managers**

USAID will support reinforcement of selected pre-service training programs so that health care staff are adequately prepared with the technical and managerial skills to deliver the required package of quality services in the field.

Illustrative Activities	
Central	<ul style="list-style-type: none"> <li>• Provide technical assistance to MOH, MINEDUC, and other educational institutions and facilities to routinely review and update curricula for health professional training in clinical and public health areas, related to HIV/AIDS, RH/FP, and Child Survival/Malaria</li> <li>• Provide continued support for the development of the School of Public Health at the National University of Rwanda for a broad range of health care providers</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Evaluate quality of current training programs at nursing schools in targeted Health Districts</li> <li>• Provide on-site training and technical assistance to District nursing schools to reinforce teaching skills, assure adequate clinical and didactic training, and update instructor technical knowledge</li> </ul>
<b>IR6.3.1 Illustrative Indicators:</b> <ul style="list-style-type: none"> <li>- Number of service delivery personnel in USAID target districts trained in their service task during the past 12 months;</li> <li>- Number of students (doctors and nurses) graduating with MPH degrees from NUR SPH;</li> <li>- Number of public health research activities conducted by the NUR SPH;</li> <li>- Number of provincial nursing schools with improved and updated competency-based training programs;</li> <li>- Number of HD and service delivery personnel (in target USAID districts) trained in public health program management</li> </ul>	

#### **IR6.3.2 – Improved health data collection and management capacities**

USAID will support improved health data collection, analysis, and utilization at all levels of the health care system to reinforce capacity of clinical and public health care providers and managers to make informed, data-based decisions.

Illustrative Activities
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Central	<ul style="list-style-type: none"> <li>• Provide on-going training and technical assistance to the NAC to implement the National HIV Monitoring and Evaluation Plan, including data analysis and report writing</li> <li>• Conduct an assessment of the current Health Information System, (HIS) and assist the MOH to develop a plan of action to strengthen data quality, and expand information collected (i.e. ARVs, home-based care, etc.)</li> <li>• Provide training to MOH regarding health data analysis and how to use data effectively in designing a National Health Sector Strategy</li> <li>• Provide training to MOH to enable integration of Quality Assurance principles into all national policies, protocols, and training materials through “collaborative” approach</li> <li>• Assist the MOH and other central organizations to design and implement scientifically valid behavioral surveys, population-based studies, and operations research related to HIV/AIDS prevention, care, and support</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Provide training to AD/HD staff, including District AIDS Committees and health centers, to reinforce local health data collection systems and enhance capacities to use data reports for making informed decisions about health care services and for health care planning</li> </ul>
Community	<ul style="list-style-type: none"> <li>• Provide basic training to community groups and leaders in health data collection and interpretation so to improve capacity to participate actively in Integrated District Health planning</li> </ul>
<b>IR6.3.2 Illustrative indicators:</b> <ul style="list-style-type: none"> <li>- Publication of an annual report on the status of Rwanda’s response to HIV/AIDS, based on the NAC M&amp;E plan</li> <li>- Number of HDs (in target USAID districts) who submit timely and accurate health data through national reporting mechanisms</li> <li>- Number of District AIDS Committees (in target USAID districts) who submit timely and accurate of health data through national reporting mechanisms</li> <li>- Number of health centers collecting and analyzing data on AIDS, TB, STIs and malaria [NAC 2.1, 2.2, 2.3]</li> </ul>	

### **IR6. 3.3 – Improved supervision and training provided by Health District**

In the decentralized health care system, the Health District team has primary responsibility for providing all in-service training and supervision for health care staff in their districts. At present, District teams are understaffed, under-trained, and under-funded to perform this important responsibility adequately. USAID will focus a significant amount of technical assistance and resources at the Health District level to enhance these capabilities.

Illustrative Activities	
Central	Assist MOH to develop national policies, procedures, guidelines needed to reinforce HIV/AIDS services within the decentralized health care system Policies and strategic plan for national scale-up of ARVs National policy for nutrition and HIV/AIDS HIV/TB co-infection protocols HIV in the workplace policies/laws Child protection strategies as a public health measure <ul style="list-style-type: none"> <li>• Advocate for increased participation and monitoring of pharmacists and traditional practitioners in STI prevention and treatment</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Reinforce HD personnel skills in training, counseling, management, and supervision to support quality services such as VCT, PMTCT, STIs, OIs, etc.</li> <li>• Provide training to all health facilities, pharmacists (and possibly traditional healers) to improve service quality of relevant aspects of HIV/AIDS management (VCT, PMTCT, ARVs, infection prevention, etc.)</li> <li>• Provide technical training and support to help health facilities expand prevention and clinical services, including linkages with community-based activities</li> </ul>

Community	<ul style="list-style-type: none"> <li>Support HD and health center staff to engage community groups in HIV/AIDS activities to advocate and monitor the quality of services</li> </ul>
<b>IR6.3.3 Illustrative indicators:</b> <ul style="list-style-type: none"> <li>Percent of STIs properly managed in health care facilities [NAC 1.9, UNGASS NP7]</li> <li># of new policies/procedures/guidelines developed for quality of care standards and integrated supervision with support from USAID</li> <li>National Index of Care and Policy of Support [NAC 3.5, UNGASS]</li> <li>Number of sites in target USAID districts with STI services [USAID]</li> <li>Number of health centers with good infection prevention and control policies, procedures, and practices [NAC 1.13]</li> <li>Number of Integrated District Health Plans funding regular informative supervision visits</li> </ul>	

#### **IR 6.4. Improved community level responses to health issues (HIV/AIDS/FP/CS Malaria)**

Community action as well as individual behavior change will be necessary to generate demand leading to increased use of community health services and adoption of health promoting behaviors. Communication, behavior change strategies, advocacy and community mobilization approaches are all required to promote changes in care seeking behavior, preventive practices, and community responses in care and mitigation for HIV/AIDS and community promotion of healthy practices related to nutrition, family planning, malaria control.

Below are IR-level indicators that will be monitored to determine progress in improving overall population knowledge and perceptions and generating a community response in terms of action taken in view of improved knowledge and perceptions. These will be measured every 2-3 years at the national level, and also through more frequent smaller scale KAP surveys in target districts.

##### **IR6.4 Illustrative Indicators:**

- Knowledge of HIV prevention methods [UNAIDS 4.1]
- No incorrect beliefs about AIDS [UNAIDS 4.2]
- Knowledge of PMTCT [UNAIDS 4.5]
- Comprehensive and correct knowledge about AIDS [UNAIDS 4.6]
- Number of USAID-assisted community and home-based care programs [NAC 3.2, USAID]

#### **IR 6.4.1 – Reinforced capacity of community groups (CBO, FBO, Associations of PLWHA, health providers) to promote positive health behaviors**

Creating capacity within the health system to develop health messages and materials, building health advocacy skills among local leaders, and improving ability among health care providers to counsel clients effectively, are all essential elements for promoting healthier behaviors among the population, especially with HIV/AIDS. Health providers deserve special attention recognizing that they are members of their local communities and may have special roles to play in the community. In some cases, they are members of FBO, caregivers and spouses of persons living with HIV/AIDS and may be infected themselves. Community groups need skills in communication, advocacy, assets and needs assessments to address HIV/AIDS, program design and learning about the situation in their community. All groups, including health providers, need support in confronting on a daily basis the challenges of HIV/AIDS. This sub IR aims to increase the ability of health providers and community groups to provide accurate information about HIV/AIDS and persons infected and affected by HIV/AIDS, and what can be done to prevent, mitigate and treat conditions. It addresses primarily actions that informed individuals can take to protect and promote the health of themselves, their families and their communities.

##### **Illustrative Activities**

Central	<ul style="list-style-type: none"> <li>• Support the NAC in developing the National HIV/AIDS BCC strategy and operational plan</li> <li>• Develop standard menu of HIV/AIDS messages for all aspects of interventions (i.e. prevention, targeted high risk groups, home-based care, destigmatization, etc.)</li> <li>• Develop catalogue of interpersonal communication strategies and tools that work in Rwanda</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Support HD in development and implementation of multi-sectoral BCC plan</li> <li>• Ensure consistency and quality of messages among district partners involved in BCC</li> <li>• Provide training for health care providers in BCC/IPC skills with suitable client education materials</li> <li>• Provide training and TA for assets and needs assessments content for HIV/AIDS, advocacy and community mobilization to CBO, FBO and public and private sector health providers</li> </ul>
<b>IR 6.4.1 Illustrative Indicators:</b> <ul style="list-style-type: none"> <li>- Development of a National HIV/AIDS BCC strategy</li> <li>- Total # condoms sold/distributed at health centers, and within the community [USAID]</li> <li>- % of health care providers demonstrating effective interpersonal communication and counseling skills</li> <li>- Number of people requesting HIV test, receiving a test and receiving test results [UNGASS 5.1, NAC 1.8]</li> <li>- % health centers in health districts with organized support system for staff;</li> <li>- % of CBO and FBO providing educational campaigns with accurate information about prevention of HIV, community services available</li> </ul>	

#### **IR 6.4.2 – Expanded capacity of community groups to respond to needs of vulnerable and at risk populations**

This sub-IR complements IR 6.4.1 by facilitating a community response to improving the health and conditions of vulnerable and at risk populations. It aims to foster participation and organized responses to HIV/AIDS by CBO, FBO and other community groups. This includes taking up of issues of stigma, conflict, allocation of resources and gender violence. This includes organization to provide home care, psychosocial support and care for vulnerable populations such as OVC, prisoners being reintegrated into their communities, widows and PLWHA. This IR also provides the opportunity for linkage with Democracy and Governance interventions. It complements increased citizen participation.

Illustrative Activities	
Central	<ul style="list-style-type: none"> <li>• Support national level initiatives to promote community response to HIV/AIDS</li> </ul>
Administrative District/ Health District (AD/HD)	<ul style="list-style-type: none"> <li>• Facilitate cross-district partnerships and learning</li> <li>• Stimulate participation in HIV/AIDS communication activities among non-traditional partners (agricultural cooperatives, private sector, faith groups, etc.)</li> <li>• Support district level initiatives to promote community response to HIV/AIDS</li> </ul>

Community	<ul style="list-style-type: none"> <li>• Provide training for community groups and leaders in integration of HIV/AIDS messages and educational materials into their activities, including topics such as HIV prevention, destigmatization, nutrition, etc.</li> <li>• Support community response initiatives to: <ul style="list-style-type: none"> <li>o Target high risk groups with appropriate strategies and messages</li> <li>o Identify and implement strategies for reducing stigma with the community</li> <li>o Promote positive living messages and strategies for families and communities affected by HIV/AIDS.</li> <li>o conduct participatory, qualitative research in order to help local communities develop responses appropriate to the unique Rwandan situation</li> </ul> </li> </ul>
<b>IR6.4.2 Illustrative Indicators:</b> <ul style="list-style-type: none"> <li>- Number of Health Districts providing HIV prevention activities to at least three high-risk target groups [NAC 1.20]</li> <li>- Number of districts sharing communication strategies and tools with other partner districts</li> <li>- Number of non-traditional partners in HIV/AIDS activities integrating HIV messages in their regular activities</li> <li>- # CBO and FBO implementing psychosocial support programs;</li> <li>- # non-traditional groups carrying out activities in response to their community circumstances;</li> <li>- #groups carrying out participatory research to inform their action plans</li> <li>- Number of households receiving help with care of orphans [UNAIDS 13.5]</li> <li>- Number of OVC programs (with USAID assistance) [NAC 4.4, USAID]</li> <li>- Number of community initiatives or community organizations receiving support to care for OVCs [USAID]</li> <li>- Number of associations of PLWA or women's groups receiving support for income-generating activities [NAC 4.5]</li> </ul>	

## F. IMPLEMENTATION MODALITIES

**Rationale** – The new strategy marks a significant turning point in USAID's health programming in Rwanda. Currently, the portfolio of activities is implemented primarily through Field Support, each partner working principally in its own technical domain (HIV/AIDS, RH/FP, orphans and vulnerable children, etc.) and in different geographic areas. Under the new strategy, USAID seeks to implement a thoroughly integrated approach. To achieve this objective, the Mission envisions two major bilateral procurements, supplemented by highly specialized technical assistance provided through a small number of Field Support partners.

**Bilateral Procurements** – Because of the Mission's integrated approach to systems-strengthening and service delivery, all the bilateral procurements will be financed with a combination of HIV/AIDS, Child Survival, Population, and Infectious Disease funds.

Each bilateral procurement will be encouraged to allocate approximately 25% of resources to national level activities (policy/norms/standards, professional training and institution strengthening), and 75% to sub-national activities at the health district, facility and community levels.

**Procurement #1: Decentralization policy/systems management contract (performance-based contract for a consortium or prime/subs)** - This institutional contract will be co-financed under the DG and Health Strategic Objectives. The contractor would have primary responsibility for the implementation of Intermediate Result 1, "Enhanced implementation of the decentralization policy in target local areas," which is a common element in the DG and Health results frameworks. This integrated, multi-sectoral approach to system strengthening is unique and its collaborative design is based upon 1) the development reality in both the Health and DG sectors, 2) an increasing interest to collaborate by the two line ministries for DG and Health, and 3) existing joint activities between the two SO teams.

Overall, the contract would aim to strengthen the policy environment and implementation of decentralized services in three tiers: enhancing national planning and management systems, improving decentralized planning and management to work toward a model of joint planning and financing, and increasing community participation in the entire program cycle, from initial planning and budgeting through to monitoring and evaluation. Approximately one-quarter of the contractor's resources will be directed to national level (policy/regulations, fiscal decentralization systems, associational strengthening) and approximately three-quarters to sub-national activities in the health district, administrative district and community levels.

**Procurement #2: Community-Health –Quality Cooperative Agreement** - This cooperating agency will provide a broad spectrum of assistance and training in USAID/Rwanda's key technical domains --- HIV/AIDS, Reproductive Health/Family Planning, and Child Survival/Malaria. A substantial portion (up to 85%) of this work will focus on HIV/AIDS. Key elements of this activity would include 1) development of a "menu of services" consistent with MOH policy for minimum package of HIV/AIDS, RH and malaria services, 2) technical assistance to strengthen quality service delivery, health communication, and monitoring/ evaluation at all program levels. Approximately one third of resources in this CA will be directed to national level activities (policy/norms/standards, professional training, institutional strengthening), and approximately two-thirds to sub-national activities in the Health District, health facilities, and community levels. The CA will initiate work during Year 1 in the same health districts as the Decentralization contractor and rapidly scale-up in year 2 in consultation with USAID and the MOH, dependent upon resources.

**One or more CAs for Community Action and OVC**, will support activities to promote increasing community response to HIV/AIDS, with a focus on care and support of OVC. The CA (or CAs) will be awarded with intent to leverage food aid resources – P.L.480 and WFP – for HIV/AIDS programming, and as such will be offered under a competition target to NGOs/FBOs with explicit linkages to food aid programs in Rwanda. Activities will target, but not be limited to, communities in the health districts covered by the two other partners noted above.

Field Support – At present, the Mission envision using five Field Support partners to provide technically specialized support. These partners may change over time as program needs evolve.

1. The **DELIVER** project has been working in Rwanda with USAID support for approximately one year. Their focus has been on strengthening the contraceptives logistics system. Under the new strategy, USAID will fund DELIVER to expand its logistics management technical assistance to include HIV/AIDS medications (i.e. antibiotics, ARVs, anti-fungal agents, etc.) and commodities (i.e. test kits, reagents, etc.).
2. The **Rational Pharmaceutical Management Plus (RPM+)** project will be funded to provide technical assistance in drug management issues, including procurement procedures (i.e. establishing drug quality standards, preparing requests for bids, analyzing bids, selecting best quality drugs at most competitive prices), design and costing of HIV/AIDS-related treatment protocols (i.e. ARVs and OIs), and developing training materials for health care providers regarding proper use of medications (i.e. indications for use, dosing guidelines, secondary effects, etc.).
3. USAID/Rwanda will fund the follow-on project to **MEASURE-DHS** to conduct a DHS-Plus in 2004/5.
4. USAID/Rwanda will fund **MEASURE-Evaluation** to continue the on-going support to the NAC for implementing the HIV/AIDS National Monitoring and Evaluation Plan.
5. **FHI/IMPACT** is currently implementing the first USAID activity to provide ARVs through core funding. In addition, IMPACT will soon recruit and place a long-term technical advisor to the NAC for developing the National HIV/AIDS BCC strategy and reinforce its technical capabilities. It is envisaged that USAID/W and USAID/Rwanda will continue to support FHI/IMPACT in Rwanda for these specific activities at least through FY04/05.

#### IV. RESULTS AND REPORTING

Magnitude and nature of expected results – USAID/Rwanda has designed an ambitious strategic intervention that is directly linked to the 5 axes of intervention outlined in the National HIV/AIDS Strategic Framework and complements activities of other partners, both geographically and programmatically. The Mission's decision to have "increased use of services" as the highest level result is appropriate given the overall emphasis of the GOR on decentralization and reinforced service delivery capacity. It is important to note, however, that the by virtue of the fact that USAID/Rwanda will implement the Integrated District Health Model in 50% of the country (20 out of 39 health districts, including the two districts with the highest HIV/AIDS prevalence) the impact of USAID/Rwanda's interventions will lead to higher level results, including national prevalence rates, risk reduction, and population coverage rates for HIV/AIDS care and treatment programs.

Consequently, USAID/Rwanda will directly support Rwanda's contribution to the international targets set for 2007:

- Reduce HIV prevalence rates among those 15-24 years of age by 50%
- Ensure that at least 25% of HIV/AIDS-infected mothers have access to antiretroviral prophylaxis to reduce HIV transmission to their infants
- Provide basic care and psychosocial support services to at least 25% of HIV-infected persons, and
- Provide community-support services to at least 25% of children affected by AIDS in high-prevalence countries

Although the National HIV/AIDS Framework currently states as its target for 2007 (end of the 2002-2007 5-year plan) to "stabilize HIV/AIDS prevalence at 13%", the GOR is revising this target based upon results from both on-going and future data collection and analyses (including the DHS Plus in 2004).

Country reporting and performance indicators and targets – The Preliminary Performance Monitoring Plan (PMP) for USAID/Rwanda's HIV/AIDS strategy is included in the Annex to this document. A summary of the baseline and targets for selected indicators are noted in the Table below. Although it is not possible at this stage to estimate the proportion of all HIV+ persons in Rwanda who receive HIV services because the denominator is currently unknown, it is possible to indicate the contribution of USAID support to the national estimate of the number of people receiving care. For example, in FY08 USAID/Rwanda projects will account for 56% of the number of women using PMTCT services and 28% of the number of HIV+ people accessing care and treatment services. Based upon results from the DHS Plus (data collection in 2004) it will be possible to estimate the denominators, i.e. the national number of HIV+ pregnant women and HIV+ individuals, and thereby estimate the proportion of need for HIV/AIDS services met in Rwanda.

Indicator from Preliminary PMP	Baseline	FY 08 target
HIV sero-prevalence rate among 15-24 year olds	8.9% (UNAIDS, 2002)	4.5%
# HIV+ pregnant women receiving ARV prophylaxis (USAID projects/National coverage)	304/1176 = 26% (program statistics 2002)	60,000/106,800 = 56%
# HIV+ persons receiving comprehensive care, including clinical and social services (USAID projects/National coverage)	85/1500 = 6% (program statistics 2003)	16500/60,000 = 28%

Additionally, as noted in the strategy, USAID/Rwanda's participation in the President's Initiative will include mandatory reporting on both PMTCT and a wider set of care and treatment indicators. USAID will also report on these indicators over the strategy period (on an annual basis, as required), and will therefore contribute to the President's overall vision for decreasing Mother to Child transmission of HIV, and increasing access to care and treatment.

Planned surveillance, surveys, and other monitoring and evaluation activities – USAID will continue to support the implementation of Rwanda’s National HIV/AIDS Monitoring and Evaluation Plan. In addition, USAID will be the principle donor financing the next Demographic and Health Survey (DHS), planned for 2004/5. This DHS will include a full HIV module as well as blood sampling to establish a reliable, population-based estimate of national seroprevalence. USAID will also continue to fund periodic behavior surveillance surveys (BSS or equivalent) every two to three years among high-risk groups such as youth and CSWs. Additionally, USAID will help support periodic, special studies identified by the National AIDS Commission (i.e. a culturally appropriate study of sexual attitudes, beliefs, and practices). At the service level, overall improvements in program management are expected to result in quality data collection and reporting at service delivery sites.

The CDC is also a critical partner in monitoring and evaluating the HIV epidemic and reinforcing institutional capacity at the central level. CDC will continue to support annual HIV sero-surveillance at ante-natal clinics. In addition, CDC plans to provide significant technical assistance and training to the TRAC to reinforce national-level capacity for collection and analysis of data from sites that offer HIV-related clinical services such as VCT, PMTCT, and ARVs.

Given the large amount of HIV/AIDS resources programmed through USAID/Rwanda, the Mission will allocate an important percentage of its funds to ensure adequate monitoring, evaluation, and accountability.

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